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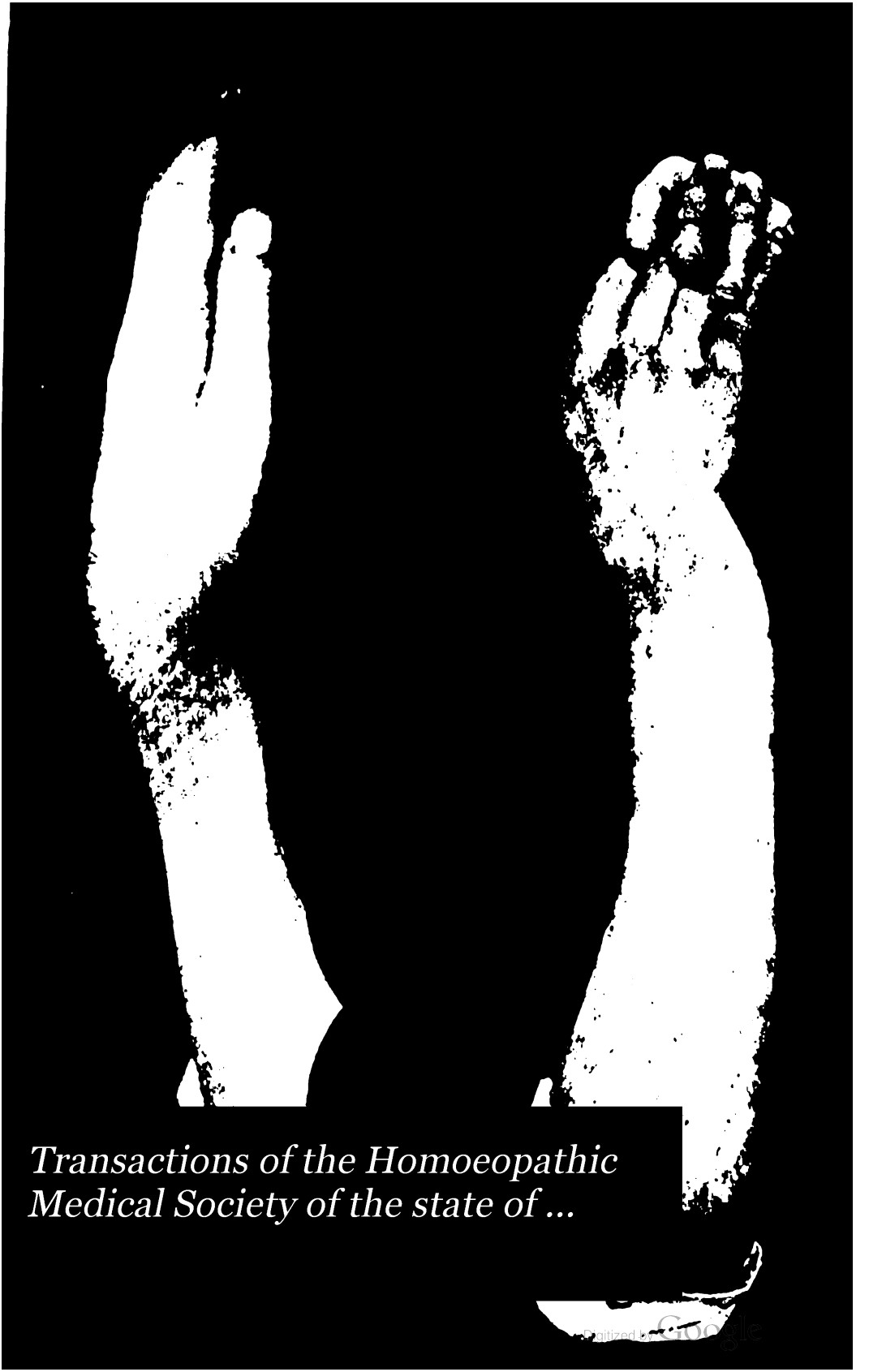

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TRANSACTIONS

OF THE

THIRTY-SECOND SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

HELD AT PHILADELPHIA, SEPT. 29, 30, AND OCT. 1, 1896.

PHILADELPHIA:
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OFFICERS.

1896.

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Necrologist,	T. S. Dunning, M.D.,	Philadelphia.
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	Wm. G. Steele, M.D.,	Philadelphia.

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	C. W. Roberts, M.D.,	Scranton.
	F. Mortimer Lawrence, M.D.,	Philadelphia.

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To the Homœopathic Medical Society of the State of Pennsylvania:

The Proceedings and Papers of the Thirty-second Session are herewith respectfully submitted. It will be noticed that the business transacted is kept separate from the papers, and that the features which had a bearing on the celebration of the centennial of the promulgation of homœopathy have been included under one rubric.

EDWARD M. GRAMM, M.D.,
J. F. COOPER, M.D.,
GEORGE B. MORELAND, M.D.,
Publishing Committee.

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TRANSACTIONS

OF THE

THIRTY-SECOND SESSION

OF THE

HOMŒOPATHIC MEDICAL SOCIETY

OF THE

STATE OF PENNSYLVANIA.

Held at the Hahnemann Medical College of Philadelphia, September 29, 30 and October 1, 1896.

THE President, WILLIAM W. VAN BAUN, M.D., of Philadelphia, called the meeting to order on the morning of September 29, 1896.

Prayer was offered by the Rev. William Neilson McVickar, D.D., of the Church of the Holy Trinity.

The President of the Homœopathic Medical Society of the County of Philadelphia, Thomas D. Dunning, M.D., welcomed the members of the Society in the following

ADDRESS OF WELCOME:

Mr. President and Members of the Homœopathic Medical Society of the State of Pennsylvania, Ladies and Gentlemen:

It is my privilege, as the official representative of the Homœopathic Medical Society of the County of Philadelphia, to give you our greeting and welcome.

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We welcome you to our city, our institutions and our homes. We feel honored in your coming, and we have made every effort to have your stay among us agreeable to you.

The most of you have been here again and again, and you come to greet old friends. Indeed, the most of you received your medical education in Philadelphia, and you owe to the beginning you made here all your present skill in the healing art.

It is but natural that you should come again to this centre of medical education for the United States, and especially to this Mecca of homœopathic medicine.

I will not say that we have all the best, but I hope I may say we have everything of the best, and a part of everything that is best.

We are glad, too, that you do not come empty-handed, for we see, on consulting the programme laid out for the Society's work, that you have brought with you a feast of fat things.

We shall *learn of you.*

We are glad that you are able thus to prove that you have not been idle, but that you have added to the knowledge obtained here, that you have observed for yourselves; and that now you can, within the walls of old Hahnemann, pay back with interest some of the teachings of Thomas, of Hering, of Lippe, of Raue, of Farrington, of Guernsey and of the men of later days. We are glad to have you here. Take possession of the place. Make yourselves at home.

The college and hospital are open to your inspection. Note well their conveniences and appliances.

We would you could make your stay reach beyond the time devoted to the Society work, that you might look about this city of ours.

We would be delighted to have you visit our homes and meet our families. The most of us have homes, though we cannot call them palatial. You know the Philadelphia physician is very modest and is careful not to charge too high fees, so we do not get rich, as they do in Chicago, or Cleveland, or New York, or Pittsburg. Still we have homes, and most of us have pleasant families in those homes. Of course we except our

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few bachelor members. There are a few of them even in Philadelphia, but they are not the fashion.

Then we would like you to look around and see the institutions of Philadelphia. Our industrial concerns are known to all. It would pay you to visit some of them.

It is not generally known how much of an educational centre Philadelphia and its vicinity have become. We have the University, with all its different departments and its 2800 students, Jefferson with its many, the Hahnemann Medical College, the Medico-Chirurgical, the Woman's Medical College, Girard College with its 1600 scholars, the Catholic schools and colleges. Each branch of the Friends has a well-endowed college besides its high schools. Then we have the high grade Woman's College at Bryn Mawr, the Theological School of the Protestant Episcopal Church, Drexel and other technical schools, and Temple College with its many departments, Peirce's and the other commercial schools, all these over and above the academies and high school system. There is much here to look into, art and technical schools and museums.

We even have sky-scrapers such as interested Li Hung Chang so much in New York. They are shooting up so high that we are somewhat afraid sometimes that they will bury our City Hall, our great marble palace, that has cost the taxpayers so dearly. It is seriously proposed to tear down a number of substantial buildings to make a plaza, so that the building may be seen more fully.

This is the city to which we bid you welcome. May you enjoy your stay and find a profit in being here.

Z. T. Miller, M.D., of Pittsburg, responded to the Address of Welcome as follows:

If you have never seen a person taken at a disadvantage, look at me. As I came into the hall this morning, your President collared me, shook me, and said that I was to respond to the Address of Welcome by the President of the Philadelphia County Society in place of Dr. Cranch, of Erie. Both Cranch and the President of the County Society had their impromptu speeches carefully written out, while I am expected to use my

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mind. I asked your President what I should say, but he failed to coach me; so, if I say nothing, your President must shoulder the responsibility. Besides, coming from Pittsburg in a sleeping-car in which there was no sleep does not tend to brighten the intellect. I feel, however, that I can assure you that every visiting member of the Pennsylvania State Society appreciates fully the welcome just extended us; and further, that they will enjoy the hospitality so kindly offered. We—many of us—left this college twenty or more years ago. We did learn something here, but we have also learned a great deal since leaving. If we can bring back with us anything that will make you the better for having us with you, our mutual interests will be conserved and our meeting a success. I thank you for the courtesy, and hope you will all profit by your attendance.

On motion, the calling of the roll was dispensed with.

It was moved and carried that the programme for the meeting, prepared by the Corresponding Secretary, be adopted, with the exception that the paper by Joseph C. Guernsey, M.D., which had been placed on the programme for presentation on Wednesday afternoon, was directed to be read on Tuesday evening.

PROGRAMME.

Order of Business.

Tuesday, September 29, 1896.

Morning Session, 10 to 1.

1. Call to order.
2. Invocation.
3. Address of Welcome, by T. S. Dunning, M.D., President of the Homœopathic Medical Society of the County of Philadelphia.
4. Response, by Edward Cranch, M.D., of Erie.
5. Roll Call. Correction of List of Members.
6. Report of Treasurer. Appointment of Auditing Committee.

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7. Report of Corresponding Secretary.
8. Report of Committees:
   a. Legislation. J. E. James, M.D., Chairman.
   b. Officinal Gardens. J. C. Guernsey, M.D., Chairman.
   c. Seal. J. F. Cooper, M.D., Chairman.
   d. Publication. J. Richey Horner, M.D., Chairman.
   e. Damage Suits. C. F. Bingaman, M.D., Chairman.
9. Report of Delegates to the American Institute of Homœopathy.
10. Report of Delegate to the Southern Institute of Homœopathy.
11. Report of Delegates from State Societies and Local Organizations.
12. Report of Board of Censors. Ella D. Goff, M.D., Chairman.
13. Report of Bureau of Organization, Registration and Statistics. George B. Moreland, M.D., Chairman.
14. Report of Necrologist.
15. Report of Auditing Committee.

Bureau of Gynæcology.

J. H. Thompson, M.D., Chairman.

Associates.—J. H. McClelland, M.D.; Mary Branson, M.D.; I. G. Smedley, M.D.; Anna C. Clarke, M.D.; H. J. Evans, M.D.; W. G. Steele, M.D.; B. F. Betts, M.D.; Eliza Lang McClure, M.D.; J. A. Bullard, M.D.; G. W. Smith, M.D.; Emma T. Schreiner, M.D.; W. D. Bayley, M.D.; M. S. Williamson, M.D.

J. H. Thompson, M.D., Pittsburg. Fixation of the Uterus in Retro-Deviations.

W. G. Green, M.D., Little Rock, Ark. The Accidents and Injuries Incident to Vaginal Hysterectomy.

J. H. McClelland, M.D., Pittsburg. Title Unannounced.

Anna C. Clarke, M.D., Scranton. As to the Wheel.

B. F. Betts, M.D., Philadelphia. The Development of Salpingitis in Young Women.

J. A. Bullard, M.D., Wilkesbarre. Electricity in Diseases of the Pelvic Viscera.

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G. W. Smith, M.D., Philadelphia. Certain Mental and Physiological Changes Following Removal of the Ovaries.

Emma T. Schreiner, M.D., Philadelphia. A Remedy Useful in Climacteric Flushing.

J. E. James, M.D., Philadelphia. Capital Operations in the Gynæcological Department of the Hahnemann Hospital of Philadelphia during the Six Months of the Session of 1895 and 1896.

I. G. Smedley, M.D., Philadelphia. Permanent Sutures as a Prevention of Ventral Hernia Following Laparotomy.

Bureau of Pathology and Pathological Anatomy.

J. E. Jones, M.D., Chairman.

Associates.—R. S. Marshall, M.D.; J. R. Phillips, M.D.; Van R. Tindall, M.D.; F. J. Slough, M.D.; J. H. Closson, M.D.; W. K. Ingersoll, M.D.

J. E. Jones, M.D., West Chester. Ulcer of the Stomach.

Van R. Tindall, M.D., Philadelphia. Pathology and Therapeutics of Appendicitis.

W. K. Ingersoll, M.D., Philadelphia. Title Unannounced.

F. M. Lawrence, M.D., Philadelphia. The Relation of the Pancreas to Diabetes Mellitus. (Presented on behalf of the Trousseau Clinical Club.)

C. Bartlett, M.D., Philadelphia. The Pathology of Erythromelalgia.

Afternoon Session, 3 to 6.

Bureau of Pædology.

M. Margaret Hassler, M.D., Chairman.

Associates.—J. E. Harner, M.D.; C. D. Smedley, M.D.; W. H. Cooper, M.D.; J. H. Sandel, M.D.; C. A. Yocum, M.D.; S. G. A. Brown, M.D.; W. J. Martin, M.D.; Mary A. Cooke, M.D.; H. C. Chisholm, M.D.; C. W. Karsner, M.D.; A. J. Bittner, M.D.

M. Margaret Hassler, M.D., Allentown. Preputial Adhesions in Little Girls.

J. E. Harner, M.D., Reading. Marasmus.

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C. D. Smedley, M.D., Wayne. Summer Diarrhœa.

W. H. Cooper, M.D., Oakmont. Eneuresis.

C. A. Yocum, M.D., Pottstown. Heredity and its Modifications in Childhood.

S. G. A. Brown, M.D., Shippensburg. The Mosaic Rite of Circumcision—A Plea for its Performance During Childhood.

W. J. Martin, M.D., Pittsburg. A Case of Tubercular Meningitis Cured with Iodoform.

Mary A. Cooke, M.D., Philadelphia. Some Thoughts on Chest Diseases of Children.

C. E. Myers, M.D., Philadelphia. The Treatment of Pneumonia in Children.

W. W. Van Baun, M.D., Philadelphia. Ulcerative Endocarditis in Childhood.

C. Bartlett, M.D., Philadelphia. The Clinical Relations of Infantile Convulsions.

Bureau of Surgery.

C. V. Vischer, M.D., Chairman.

Associates.—L. H. Willard, M.D.; R. W. McClelland, M.D.; C. P. Seip, M.D.; J. E. James, M.D; G. A. Mueller, M.D; W. B. Van Lennep, M.D.; L. W. Thompson, M.D.; H. L. Northrop, M.D.; Walter Strong, M.D.

C. V. Vischer, M.D., Philadelphia. Resumé of Progress.

W. B. Van Lennep, M.D., Philadelphia. Title unannounced.

H. L. Northrop, M.D., Philadelphia. Strangulated Hernia and the Murphy Button.

Walter Strong, M.D., Philadelphia. Fractures Involving the Elbow-Joint.

W. D. Bayley, M.D., and C. V. Vischer, M.D., Philadelphia. Cases Illustrating Brain Localization and Surgery.

D. P. Maddux, M.D., Chester. A Case of Brain Abscess.

J. W. Hassler, M.D., Philadelphia. Shock After Anæsthesia.

Evening Session, 8.30.

William W. Van Baun, M.D., Philadelphia. President's Annual Address.

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Augustus Korndœrfer, M.D., Philadelphia. The Homœopathy of Hahnemann.

J. C. Guernsey, M.D., Philadelphia. Samuel Hahnemann, the Medical Reformer of the Eighteenth Century.

T. L. Bradford, M.D., Philadelphia. The True Story of Hahnemann's Grave.

L. H. Willard, M.D., Allegheny, Chairman. Report of Committee on Hahnemann Statue.

Wednesday Morning Session, 9.30 to 1.

BUREAU OF SANITARY SCIENCE.

Pemberton Dudley, M.D., Chairman.

Associates.—B. W. James, M.D.; A. W. Baily, M.D.; T. H. Carmichael, M.D.; I. B. Gilbert, M.D.; E. H. Kase, M.D.; W. H. Malin, M.D.; C. R. Norton, M.D.; T. P. Gittens, M.D.; J. F. Cooper, M.D.

Pemberton Dudley, M.D., Philadelphia. Some Sanitary Needs of Pennsylvania.

B. W. James, M.D., Philadelphia. Sanitary Notes.

I. B. Gilbert, M.D., Philadelphia. Hygiene.

A. W. Baily, M.D., Atlantic City, N. J. The Disinfection of Sputa.

BUREAU OF CLINICAL MEDICINE.

Z. T. Miller, M.D., Chairman.

Associates.—A. P. Bowie, M.D.; E. C. Parsons, M.D.; W. C. Goodno, M.D.; E. R. Snader, M.D.; T. Hart Smith, M.D.; M. R. Jamison, M.D.; F. W. Burlingame, M.D.; P. A. Bier, M.D.; J. S. Boyd, M.D.; J. C. Morgan, M.D.; W. W. Van Baun, M.D.; Chandler Weaver, M.D; R. E. Tomlin, M.D.

Z. T. Miller, M.D., Pittsburg. "The Middle of the Road" in Medicine.

Eugene H. Porter, M.D., New York. Diagnosis and Treatment of Ulcer of the Stomach.

Edwin H. Wolcott, M.D., Rochester, N. Y. Albuminuria.

A. P. Bowie, M.D., Uniontown. On the Importance of Mental Symptoms in the Selection of the Remedy for the Sick.

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W. C. Goodno, M.D., Philadelphia. Title unannounced.

E. R. Snader, M.D., Philadelphia. On the Danger of Neglecting Bronchitis.

M. R. Jamison, M.D., Greensburg. Bromine in Diphtheria, Croup, and Diseases of Nerve Centres in Children—Cases.

F. W. Burlingame, M.D., McKeesport. Gonorrhœa.

P. A. Bier, M.D., Pittsburg. A Singular Case.

J. C. Morgan, M.D., Philadelphia. Cases of Gonorrhœa in Male and Female Patients.

Chandler Weaver, M.D., Philadelphia. A Case of Neuritis of the Sciatic Nerve Cured.

R. E. Tomlin, M.D., Philadelphia. A Consideration of the Evils of Artificial Methods for Preventing Fecundation and Abortion Production.

R. T. White, M.D., Allegheny. A Comparative Study of the Urinary Indications of Chimaphila Umbellata and Fabiana Imbricata.

Afternoon Session, 3 to 6.

BUREAU OF MATERIA MEDICA.

R. T. White, M.D., Chairman.

Associates.—C. S. Middleton, M.D.; E. M. Gramm, M.D.; Edward Cranch, M.D.; J. S. Rankin, M.D.; Charles Mohr, M.D.; T. S. Dunning, M.D.; G. W. Stewart, M.D.; C. S. Schwenk, M.D.; W. G. Dietz, M.D.; J. C. Guernsey, M.D.

R. T. White, M.D., Allegheny. Rational Hypotheses of Drug Dynamics.

C. S. Middleton, M.D., Philadelphia. Materia Medica Building and the Selection of the Remedy.

E. M. Gramm, M.D., Philadelphia. Calotropis Gigantea.

Edward Cranch, M.D., Erie. Apis and Zinc.

The Pharmacological Society of the Hahnemann Medical College. Original Provings.

Charles Mohr, M.D., Philadelphia. Comments on Provings by the Pharmacological Society.

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C. S. Schwenk, M.D., Philadelphia. The Materia Medica.

W. G. Dietz, M.D., Hazleton. Notes on Ferrocyanide of Potash.

B. W. James, M.D., Philadelphia. Some of the Proven Homœopathic Remedies in Use by the Old School.

Wednesday Evening, 8.

Banquet at the Hotel Walton, tendered to the visiting physicians and their ladies by the physicians of Philadelphia and vicinity.

Thursday Morning Session, 9.30 to 1.

BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

H. B. Bryson, M.D., Chairman.

Associates.—C. M. Thomas, M.D.; W. W. Blair, M.D.; H. F. Ivins, M.D.; William Spencer, M.D.; H. K. Hoy, M.D.; W. H. Lee, M.D.; W. H. Bigler, M.D.; John Cooper, M.D.; I. G. Shallcross, M.D.; H. I. Jessup, M.D.; C. H. Lee, M.D.; G. H. Haas, M.D.

H. B. Bryson, M.D., Pittsburg. Resumé of Progress.

C. M. Thomas, M.D., Philadelphia. Title unannounced.

William Spencer, M.D., Philadelphia. The Treatment of Progressive Myopia of High Degree by Operative Measures.

W. H. Lee, M.D., New Castle. Homœopathy *vs.* Allopathy in the Treatment of Injuries of the Eyes.

W. H. Bigler, M.D., Philadelphia. What Should be the Aim of the Refractionist.

W. W. Blair, Pittsburg. Title unannounced.

C. H. Lee, M.D., New Castle. Chronic Hypertrophic Rhinitis (a few cases).

H. I. Jessup, M.D., Philadelphia. Changes in Refraction Following Iritis.

H. F. Schantz, M.D., Reading. Ophthalmia Neonatorum.

W. G. Steele, M.D., Philadelphia. Orificial Surgery with Relation to the Nasal Reflexes.

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Bureau of Obstetrics.

Ella D. Goff, M.D., Chairman.

Associates.—J. R. Horner, M.D.; B. L. Davis, M.D.; W. S. Bigelow, M.D.; T. J. Gramm, M.D.; W. F. Edmundson, M.D.; W. R. Stephens, M.D.; Pearl Starr, M.D.; Millie J. Chapman, M.D.; Augustus Korndœrfer, M.D.; Hugh Pitcairn, M.D.; Sarah J. Coe, M.D.; J. N. Mitchell, M.D.; E. W. Mercer, M.D.; Anna M. Marshall, M.D.

Ella D. Goff, M.D., Allegheny. Dropsy in Pregnancy (with a case).

J. R. Horner, M.D., Allegheny. The Great Lying-in Hospitals of London.

W. S. Bigelow, M.D., Phillipsburg. A Case of Breech Presentation with the Funis Wound Around the Leg Above the Knee.

T. J. Gramm, M.D., Philadelphia. The Present Status of Puerperal Infection.

Pearl Starr, M.D., Bellevue. Anomalous Pregnancies.

J. N. Mitchell, M.D., Philadelphia. Title unannounced.

Afternoon Session, 3 Until Adjournment.

Final Report of the Board of Censors.
Conclusion of reports and discussions.
Report of Committee on President's Address.
Unfinished Business.
New Business.
Election of Officers.
Selection of place for the next meeting.
Appointment of Committees.
Announcement of Bureaus.
Adjournment.

The Treasurer, J. F. Cooper, M.D., presented the following report, which was received and referred to an auditing committee, consisting of Z. T. Miller, M.D., T. H. Carmichael, M.D., and John C. Morgan, M.D.:

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REPORT OF THE TREASURER.

J. F. Cooper, M.D., in account with Homœopathic Medical Society of Pennsylvania.

Dues collected from September 17, 1895, till September 28, 1896:

From 155 members, ...		$894 00
And paid the following bills of the Society:		
J. W. Vickerman & Co., for printing, .	$38 55	
H. E. Ramsey, Stenographer, . . .	50 00	
Corresponding Secretary, ...	52 40	
E. R. Snader's bill, ...	15 34	
Sherman & Co., for printing, binding, boxing and mailing TRANSACTIONS, . .	695 90	
Corresponding Secretaries' last bill, . .	20 83	
Balance due the Society, ...	20 98	
		$894 00

Respectfully submitted,

J. F. COOPER, M.D.,
Treasurer.

The President announced that he had received a communication from the American Institute of Homœopathy, requesting that the State Society appoint a committee to confer with committees from other State Societies and from the American Institute of Homœopathy, on the subject of endeavoring to have laws passed which would place the profession in the different States on a similar basis and under similar statutes. He stated that he had named Pemberton Dudley, M.D., of Philadelphia, and J. H. McClelland, M.D., of Pittsburg, such a committee until the meeting of the Society, and asked that his action be endorsed and the members named approved as the committee. On motion the action requested was taken.

The report of the Corresponding Secretary was read and referred to the Committee on Publication.

REPORT OF THE CORRESPONDING SECRETARY.

Your Corresponding Secretary respectfully reports that he has carried on the correspondence of the Society since the last

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meeting, and by that means has kept in touch with the various other State Societies and the American Institute of Homœopathy. The physicians of our State have shown a decided interest in the State Society, and particularly in the advancement of its good at the present meeting.

About one thousand programmes of the meeting have been circulated in the State, members and non-members having been reached by these means, and the excellent papers and discussions brought to their attention. Applications for membership have followed the receipt of the programme in several instances.

An important communication was received from the Secretary of the World's Congress of Medico-Climatology, asking for the appointment of ten delegates from the State Society to the Congress. The President, Dr. Van Baun, appointed the following delegates:

Pemberton Dudley, M.D., B. W. James, M.D., J. H. McClelland, M.D., Hugh Pitcairn, M.D., A. P. Bowie, M.D., Edward Cranch, M.D., W. E. Rotzell, M.D., Sarah J. Coe, M.D., Joseph E. Jones, M.D., J. Richey Horner, M.D.

EDWARD M. GRAMM, M.D.,
Corresponding Secretary.

On motion, the action of the President in making the appointments just mentioned was endorsed and the appointees continued.

REPORT OF THE BUREAU OF ORGANIZATION, REGISTRATION AND STATISTICS.

Your Bureau of Organization, Registration and Statistics herewith presents its annual report.

Since the last report of this Bureau 15 active members have been added to the State Society, giving us at present an active membership of 287, together with 11 honorary and 5 corresponding members.

Twenty-two local societies were reported last year. The report this year shows an increase of three. Twenty-four of these societies have a membership of 1064, a gain of 356 over last year.

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The Alumni Association of Hahnemann Medical College has added 81 members to its roll, making a total of 1110.

The entire membership of the twenty-five societies is 2174.

Two new societies were formed during the year, the Homœopathic Practitioners' Association of Reading, Pa., with a membership of 12, and the Hahnemannian Association of Western Pennsylvania, with 275 members. This latter society is composed of both the laity and the profession, and meets annually to commemorate the birth of Samuel Hahnemann. Its object is not only to honor the memory of Hahnemann, but in gathering together men prominent in the community and known for their intellectual talents, to demonstrate that the living truth of the Law of Similars is believed in by them, and not alone by those not yet qualified or endowed by nature to speak its praises or sound its merits.

The idea is a worthy one, and should commend itself to other sections of the State.

One society, the Homœopathic Medical Society of Chester, Delaware and Montgomery Counties, with a membership of 30, which was formed some years ago, has been added to our list.

The hospitals, dispensaries and institutions under homœopathic control have had an unusually successful year. In addition to those reported last year, we desire to include a report from the Protestant Home for Incurables of Pittsburg, from the St. Luke's Homœopathic Hospital and Dispensary of Philadelphia, and from the Homœopathic Dispensary of Reading, Pa.

One of the medical journals reported last year, the *International Brief*, has ceased to exist under that name, and is, therefore, omitted from this year's report.

The other journals continue to be as readable and as active in their several spheres as formerly. Two new publications have been added. One, the *Hahnemannian Institute*, is published under the auspices of the College Society of Hahnemann, Philadelphia. The other, the *Hospital News*, is edited by the resident physicians of the Homœopathic Hospital of Pittsburg.

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We realize that there are societies and institutions in the State under homœopathic management that have not been included in this report. We would suggest to any member knowing of such that he report them to the Recording Secretary, or send them to any of our journals. They will be reported there, and the Secretary will find them.

We beg to acknowledge, through the medium of this report, our thanks for the courteous and prompt responses received from the societies, hospitals, dispensaries and journals enumerated therein.

Respectfully submitted,

GEO. B. MORELAND, M.D., Chairman.
J. F. COOPER, M.D.,
EDWARD M. GRAMM, M.D.

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HOMŒOPATHIC DISPENSARIES

NAME.	Location.	Secretary or Executive Officer.
Homœopathic Free Dispensary.	Pittsburg.	W. D. Slack, Sup't.
Hahnemann Hospital Free Dispensary.	Philadelphia.	Wm. G. Foulke, 221 S. 5th St.
Children's Homœopathic Hospital Dispensary.	Philadelphia.	N. B. Kelly, 26 S. 15th St.
Dispensary of Women's Homœopathic Association of Penna.	Philadelphia.	Mrs. F. B. Skinner.
St. Luke's Homœopathic Dispensary.	Philadelphia.	John M. Zirk.
Reading Homœopathic Dispensary.	Reading.	H. F. Schantz, M.D.

HOMŒOPATHIC HOSPITALS AND INFIRMARIES

NAME.	Location.	Executive Officer.	When Incorporated.	When Opened to Patients.	No. of Beds.
Medical, Surgical and Maternity Hospitals of the Women's Hom. Association of Penna.	Philada.	Mrs. F. B. Skinner, Secretary, Provident Building.	1882	1884	75
Home for the Aged Poor, Little Sisters of the Poor.	Pittsburg.	Sister Romaine Mari Supt.	1874	1884	152
Homœopathic Hospital and Dispensary.	Reading.	W. W. Light, Sec'y.	1890	1891	16
Children's Homœop. Hospital.	Philada.	N. B. Kelly, 26 S. 15th St.	1877	1877	50
Christian Home for Women.	Allegh'ny	Mrs. F. K. Smith, 728 Euclid Av., Pittsb'g.	1868	1868	23
Homœopathic Medical and Surgical Hospital.	Pittsburg.	W. D. Slack, Supt.	1866	1866	150
Hahnemann Medical College Hospital.	Philada.	W. G. Foulke, Franklin Bldg.	1848	1869	140
Protestant Home for Incurables.	Pittsburg.	Mrs. Geo. Taylor.			60
St. Luke's Homœopathic Hospital of Philadelphia.	Philada.	S. M. Barnes, 3517 N. Broad St.	1896	1896	12
Woman's Southern Homœopathic Hospital.	Philada.		1896	1895	

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OF THE STATE OF PENNSYLVANIA.

Incorporated.	Opened to Patients.	No. of New Patients Last Year.	No. of Patients Treated Last Year.	No. of Prescriptions Last Year.	Cost of conduct'g	No. Visits to Out-Door Patients.	DELEGATE.
					$		
1866	1866	.....	15,943	.....	...	...	.....
1848	1848	.....	25,807	91,424	18,064	1742	.....
1877	1877	.....	32,013	.....	...	4676	B. W. James, M.D.
1882	1884	.....	3,282	10,021	...	1569	.....
1896	1896	.....	4,672	4715	...	...	.....
1890		.....	872	2989	...	208	H. F. Schantz, M.D.

OF THE STATE OF PENNSYLVANIA.

No. of Patients Treated Last Year.	Cured.	Relieved.	Not Relieved.	Died.	Estimated Value of Hospital and Grounds.	Amount of Productive Prop'ty	Sources of Income.	DELEGATE.
					$	$		
471	354	37	15	19	216,000.00		Donations	.....
45	7	15	2	21	150,000.00	None.	"	.....
132	108	9	5	10	35,000.00	"	"	H. F. Schantz, M.D.
247	176	28	11	10	85,000.00	"	"	B. W. James, M.D.
24	20	0	0	4	25,000.00	450.00	"	.....
1703	1181	262	68	85	60,000.00	81,139.82	"	.....
2029	1644	140	43	122	600,000.00	215,000.00	"	C. Mohr, M.D.
52	0	10	0	8	.....	.....	"	Jos. H. Thompson, M.D.
128	112	5	2	9	15,000.00	None.	"	.....
						None.	"	Eliza Lang McClure, M.D.

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HOMŒOPATHIC MEDICAL SOCIETIES

NAME.	PRESIDENT.	SECRETARY.
Lehigh Valley Homœo. Medical Society.	E. D. Doolittle, M.D., Easton.	H. A. Fehr, M.D., 221 N. 9th, Allentown.
Hom. Medical Society of Northern Penna.	A. A. Lindabury, M.D., 210 S. Main St., Scranton.	Anna C. Clarke, M.D., 426 Adams Ave, Scranton.
Hom. Medical Society of Allegheny County.	R. T. White, M.D., 53 Jackson St, Allegheny.	W. C. Cook, M.D., 327 Grandv'w Av., Pittsbg
Hom. Pharmaceutical Association of Penna.	F. J. Slough, M.D., Allentown.	E. P. Anshutz, M.D., Philadelphia.
Bœnninghausen Club of Philadelphia.	Geo. W. Parker, M.D., 1404 S. Sixth St, Phila.	Geo. W. Smith, M.D., 806 N. Broad St., Phila.
Philadelphia Clinical Society.	C. M. Thomas, M.D., 1623 Arch St., Phila.	Wm. H. Bigler, M.D., 118 N. 17th St., Phila.
Philada. Medical Club.	Carl V. Vischer, M.D. 1429 Poplar St., Phila.	E. W. Mercer, M.D., 157 N. 15th St., Phila.
Hom. Med. Society of 23d Ward, Philada.	T. J. Gramm, M.D, 846 N. Broad St., Phila.	S. G. Godshall, M.D., Edge Hill.
Beaver County Hom. Medical Society.	J. C. McCauley, M.D, Rochester.	Wm. Raymer, M.D., Beaver Falls.
Alumni Assocn. of Hahn. Med. College of Phila.	L. H. Willard, M.D, Allegheny City.	Wm. W. VanBaun, M.D., 1402 Spruce St., Phila.
Hom. Medical Society of County of Philadelphia.	Thos. S. Dunning, M.D, 1328 N. 15th, Phila.	W. Dod Bayley, M.D, 1434 Poplar, Phila.
Hahnemann Club of Philadelphia.	Bushrod W. James, M.D., 18th and Green, Phila.	Thos. S. Dunning, M.D., 1328 N. 15th, Phila.
Schuylkill County Hom. Medical Society.	M. S. Kessler, M.D., Shenandoah	A. P. Seligman, M.D., Mahoning City.
South Central Pennsylvania Hom. Med. Society.	S. G. A. Brown, M.D., Shippensburg.	J. B. Spangler, M.D., Mechanicsburg.
A. R. Thomas Club (formerly the Hahnemann Clinical Club of Phila.)	Weston D. Bayley, M.D., 1434 Poplar, Phila.	A. A. Norris, M.D., 4818 Chester Ave., Phila.
Homœopathic Med. Soc. of Germantown.	William Malin, M.D. Chestnut Hill, Phila.	J. H. Closson, M.D., 53 W. Chelten Ave., Germant'n.
Women's Hom. Medical Club of Philadelphia.	Harriet J. Sartain, M.D., 212 W. Logan Sq., Phila.	Anna M. Marshall, M D., 1928 Chestnut, Phila.
Trousseau Clinical Club.	F. M. Lawrence, M.D, 2840 Ridge Ave, Phila.	Wm. D. Culin, M D., 4028 Parrish, Phila.
Pharmacological Society of the Hahn. Medical College of Phila	Chas. Mohr, M.D., 1823 Green, Phila.	Chas. A. Ayres, M.D., 1643 S Broad, Phila.
Saturday Night Club of Microscopists.	J. C. Guernsey, M D., 1923 Chestnut, Phila.	Nathan Smilie, M.D., 249 W. Logan Sq., Phila.
East End Doctors' Club.	J. H. McClelland, M.D, 5th & Wilkins, Pittsburg.	R. S. Marshall, M D., Penn & Highland. Pittsb'g
Oxford Medical Club.	E. R Snader, M.D., 140 N. 20th, Phila.	C. H. Brown, M D., 1824 Diamond, Phila.
Hom. Medical Society of Chester, Delaware and Montgomery Counties	Jos. E. Jones, M.D., West Chester.	Isaac Crowther, M.D., Chester
Hom. Practitioners' Association of Reading, Pa.	J. I. Keen, M.D., 1213 Chestnut, Reading.	F. W. Seidel, M.D., 362 N. Front, Reading.
Hahnemann Association of Western Penna.	A. H. Childs, M.D., Pittsburg.	J. H. McClelland, M.D., Pittsburg.

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OF THE STATE OF PENNSYLVANIA.

When Organized.	When Incorporated	When Meetings are held.	Where Meetings are held.	No. Members.	No. Admitted Last Year.	No. Deceased Last Year.	Annual Dues.	Publications.	Delegate.
1881	Not.	Bi-Month.	Members' Residences.	30	1	1	$1.00	Papers	M. Hassler, M.D.
1879	"	Monthly.	Scranton & Wilkesb'e.	25	1	0	2.00	"	Dr. Clarke. Dr. Sandel.
1864	"	" (2d Fri.)	Homœop. Hospital.	62	8	0	2.00	"	W. J. Martin, M.D.
1881	1881	At call of President.	Philada.	13	0	0	none	.....	.....
1877	Not.	Monthly. (4th Wed.)	Philada.	8	0	0	6.00	Papers	.....
1880	"	S.-M'nthly.	Members' Residences.	10	0	0	1.00	"	.....
1880	"	Monthly. (1st Wed.)	"	11	0	0	none	"	.....
1881	"	Monthly. (3d Wed.)	"	24	2	1	1.50	"	R. C. Allen, M.D. A. D Krewson, M.D.
1883	"	Monthly.	"	15	3	1	1.00	"	.....
1857	"	Annually.	Philada.	1110	81	15	.....	Jour'ls	L. H. Willard, M.D.
1866	"	Monthly. (2d Thur.)	Hahn. College.	270	28	4	1.00	Papers	E. L. McClure, M.D. I. G. Smedley, M.D.
1872	"	Monthly.	Members' Residences.	10	0	1	.....	"	John E. James, M.D.
1883	"	Quarterly.	"	22	2	0	1.00	"	.....
1894	"	No stated time.	Harrisburg	26	5	0	1.00	"	.....
1888	"	Monthly. (2d Wed.)	Members' Residences.	17	1	0	.....	"	.....
1877	"	Monthly.	"	81	0	0	.....	"	.....
1883	"	Monthly. (3d Fri.)	"	18	4	1	1.00	"	.....
1895	"	Monthly. (1st Mon.)	Philada.	21	9	1	6.00	"	F. M. Lawrence, M.D.
1895	"	Monthly. (1st Tues.)	"	25	0	0	2.00	.....	.....
1894	"	Monthly. (2d Sat.)	Hahn. College.	30	12	0	1.00	Papers	.....
1895	"	Monthly. (1st Sat.)	Members' Residences.	15	0	0	1.00	"	.....
1885	"	Monthly. (4th Fri.)	"	14	2	0	1.00	"	.....
1858		Bi-m'nthly	No stated place.	30	1	0	1.00	"	R. P. Muser, M.D.
1896		Monthly. (1st Tues.)	Members' Residences.	12	12	0	1.00	"	H. F. Schantz, M D.
1896		Annually.	No stated place.	275	275	0	2.00	.....	.....

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HOMŒOPATHIC MEDICAL JOURNALS OF THE STATE OF PENNSYLVANIA.

NAME.	EDITORS AND PUBLISHERS, AND PLACE OF PUBLICATION.	When Established.	Pages in each Number.	Subscription Price.	How often Published.	FORM.	DELEGATE.
Hahnemannian Monthly	W. W. VanBaun, M.D., 1402 Spruce St., Phila. Wm. H. Bigler, M.D., 118 N. 17th St., Phila. Clarence Bartlett, M.D., 1506 Arch St., Phila. Wm. B. Van Lennep, 1421 Spruce St., Phila.	1865	96 Total 138	$3.00	Monthly	Octavo.	W.W.Van Baun, M.D.
Homœopathic Envoy.	E. P. Anshutz, P. O. Box 921, Phila.	1890	8	.25	Monthly	Quarto.	.....
Homœopathic Recorder.	E. P. Anshutz, P. O. Box 921, Phila. Boericke & Tafel, 1011 Arch St., Phila.	1886	48	1.00	Monthly	Octavo.	.....
The Homœopathic Physician.	Walter M. James, M.D., 1231 Locust St., Phila.	1881	48	2.50	Monthly	Octavo.	.....
Hospital News.	Verner S. Goggin, M.D., Pittsburg, Pa. Roy C. Pitcairn, M.D., Pittsburg, Pa. Homœopathic Hospital, Pittsburg, Pa.	1896	8	Gratuitous.	Monthly	.....	.....
Hahnemannian Institute	Elected by Students, Philadelphia, Pa.	1893	16	.50	Monthly during Col. Term	Quarto.	.....

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J. F. Cooper, M.D., the Chairman of the Committee on Seal, presented to the Society the seal which the Committee had been instructed to obtain. The Committee was, thereupon, discharged, with the thanks of the Society.

C. F. Bingaman, M.D., the Chairman of the Committee on Damage Suits, presented as its report a bill which it had drawn up for presentation to the Legislature, and which was referred to the Committee on Legislation for action thereon.

REPORT OF THE BOARD OF CENSORS.

The Board of Censors examined into the professional standing of the following applicants for membership, and recommended that they be elected. On motion, the recommendations of the Board of Censors were adopted, the candidates balloted for and elected.

Albra W. Baker, M.D., ... Emporium.
J. P. Birch, M.D., . . . 3801 Powelton Ave., Phila.
Mary Brewer, M.D., . 330 E. Chelten Ave., Gtn., Phila.
Joseph M. Caley, M.D., . . . 1513 Green St., Phila.
L. K. Esrey, M.D., ... 1642 Pine St., Phila.
P. Sharples Hall, M.D., . . 1604 Arch St., Phila.
J. G. Keelor, M.D., . 48th and Baltimore Ave., Phila.
Augustus Korndœrfer, Jr., M.D., . 1728 Green St., Phila.
Edward A. Krusen, M.D., ... Collegeville.
Wm. Howard Lyle, M.D., . . 1833 Master St., Phila.
A. F. Merrell, M.D., ... Hallstead.
Charles R. Palmer, M.D., ... West Chester.
Franklin Powel, M.D., ... Chester.
James P. Pursell, M.D., ... Easton.
John L. Redman, M.D.,
1618 Pacific Ave., Atlantic City, N. J.
Jonathan T. Ridge, M.D., . . 1617 N. 7th St., Phila.
Henry F. Schantz, M.D.,
30 National Bank Building, Reading.
Charles E. Spahr, M.D., ... York.
Robert Steudel, M.D., ... Phœnixville.
Theodore Surreth, M.D., ... Scranton.

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ALBIN E. TORTAT, M.D.,	3727 Ridge Ave., Phila.
CHARLES S. TRITES, M.D.,	4500 Baker St., Myk., Phila.
SILVESTER ULRICH, M.D.,	Middletown.
G. A. VAN LENNEP, M.D.,	1421 Spruce St., Phila.
ROBERT WALTER, M.D.,	Walter's Park.
MAURICE D. YOUNGMAN, M.D.,	Atlantic City, N. J.

REPORT OF THE NECROLOGIST.

In the list of our deceased brothers this year we find a number of distinguished members, and the Society has suffered heavily. This has been especially so in Philadelphia and vicinity.

Dr. Amos Russell Thomas, Dean of the Hahnemann College, and for many years the highly esteemed Professor of Anatomy there, died at Devon, October 31, 1895, after a lingering illness.

He was born at Watertown, N. Y., October 3, 1826, being descended from Welsh ancestors. His father was Colonel Azariah Thomas, who served under General Jacob Brown, in the war of 1812 on the northern frontier. He was early thrown upon his own resources, acquiring his education by his unaided efforts. His robust and vigorous frame was largely owing to his work upon a farm in his early days. His leisure hours he devoted to study, and thus fitted himself to teach school, which he did in western New York. In 1850 he engaged in mercantile pursuits, but finding this uncongenial, he turned his attention to professional work. Obtaining possession of an Indian's skull, which had been exhumed near his place of business, he borrowed a work on anatomy for the purpose of studying this skull. He soon became so interested that he determined to study medicine.

In 1854 he graduated from Syracuse Medical College. Then he came to Philadelphia, and taking a course of lectures from the Pennsylvania Medical University, graduated again. He was immediately offered the position of demonstrator of anatomy there. This he accepted and made Philadelphia his home, holding this position for ten years. In 1856 he was made Pro-

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fessor of Artistic Anatomy in the Pennsylvania Academy of Fine Arts, being the first in the world to fill such a position. In 1863 he was appointed to the same position in the School of Design for Women.

After the second battle of Bull Run, during the War of the Rebellion, he volunteered as a surgeon, and was assigned to duty in the Armory Square Hospital in Washington, where he remained until the wounded from that field were cared for.

He returned to Philadelphia and resumed his practice, which was lucrative and select. About this time he became interested in Homœopathy, and soon adopted that system. In 1867 he was called to the Chair of Anatomy in the Hahnemann Medical College of Philadelphia, which position he acceptably filled until disease laid him low. After the retirement of Dr. Hering, in 1874, he took upon him the arduous duties of Dean of the College.

May, 1894, the Alumni of Hahnemann College celebrated the fortieth anniversary of his service as a teacher of anatomy, by raising the sum of $5000, to endow a bed in the Hahnemann Hospital in perpetuity, to be called "The Amos Russell Thomas Free Bed."

As a lecturer on anatomy Dr. Thomas was remarkably clear and concise, and his manner at once attracted the attention and held it close to the subject.

He found time to deliver many addresses and write many papers. He had been President both of the Philadelphia County and of the Pennsylvania State Homœopathic Societies.

He had written an excellent treatise on Post-Mortem Examinations and Morbid Anatomy, and for five years was general editor of the *American Journal of Homœopathy and Materia Medica*, and for a few months was associated with Dr. McClatchey in the *Hahnemannian*.

His greatest work was in building up the Hahnemann College and Hospital and in bringing about an improvement in medical education. Largely through him the requirements for admission to the college and the grade of the course were raised to the present high standard.

In his death the homœopathic community felt they had met

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a great loss. The profession called his friends to a memorial meeting held in Association Hall, at which Dr. Dudley spoke in behalf of the faculty, Dr. J. H. McClelland of Pittsburg, dwelt upon the relation of Professor Thomas to the profession as a teacher, as a leader in advancing the cause of medical education, as a leader of men without their feeling they were led, of his work in building up the magnificent college which now shelters our meetings, and then he spoke of his personal associations with him. Dr. McVickar and Mr. George C. Thomas spoke for the laymen.

Dr. Thomas was a member of the Philadelphia County Society, the Pennsylvania State Society, the American Institute of Homœopathy, the Fairmount Park Art Association, the Pennsylvania Horticultural Society, the Academy of Natural Sciences, the Historical Society of Pennsylvania and a member of the Anatomical Board of the State of Pennsylvania from July, 1883, the date of its organization, until his death.

His wife survives him, as does his distinguished son, the former well-known surgeon and now brilliant Professor of Ophthalmology, Dr. Charles M. Thomas.

Dr. Mahlon M. Walker, a leading physician of Germantown, died, March 31st, at the Hahnemann Hospital, whither he had been taken that day for treatment. He had been suffering from obscure chest pains and gastric distress for some weeks. As he grew no better, it was thought best to remove him to the hospital for constant watching, but he died a short time after his arrival, from rupture of an aneurism of the thoracic aorta.

Dr. Walker was born in Bucks County. His parents, and ancestors from the time of Penn, were members of the Society of Friends. His education was received in the Central High School of Philadelphia. At nineteen years of age he was appointed principal of the Morrisville Grammar School. From this he resigned to study medicine under the direction of Dr. Thomas Moore, of Germantown. He graduated from the Hahnemann Medical College in 1867 and located in Germantown, where he resided until his death. Here he had a large and lucrative practice. In 1868 he went to Europe with Dr. B. F. Betts, visiting the medical schools.

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Dr. Walker has been associated in most of the medical work of Germantown and Philadelphia since he settled there. He was an active member of the Hahnemann Club, of the County and State Societies, and of the American Institute, also of the Historical Society and of the Academy of Natural Sciences.

He was courteous and cordial in his manners and made many friends.

Dr. Walker leaves a widow and three children, a son and two daughters.

Dr. C. G. Raue, who died at his home, 121 North Tenth Street, Philadelphia, on August 21, 1896, of general debility, was born in Nieder Cunnersdorf, a village near Lobau, Saxony, on May 11, 1820. He was, therefore, in his seventy-seventh year.

After his own school-life, the last four years of which was spent in the college for teachers at Bautzen, he taught school for several years at Benkau. There he wrote his first work on psychology, *Die Neue Seelen-Lehre Beneckes*, which appeared in 1847 and passed through several editions, the last in 1876. This work was extensively used as a text-book, and has been translated into the English, French and Flemish languages.

At this time in his life he determined to carry out the desire of his life and to become a physician. In 1848 he left his native home and came to Philadelphia, where he met Dr. Constantine Hering, and told of his desire to study medicine. He now availed himself of every opportunity to become a thorough physician. He graduated in the Philadelphia College of Medicine in 1850, and under the direction of Dr. Hering he gained much knowledge of practical medicine, and especially of the new therapeutics.

He practiced in Trenton, N. J., for several years, but in 1858 he returned to Philadelphia. He became associated with the work of the Homœopathic Medical College of Pennsylvania, and was elected to the chair of Special Pathology and Therapeutics in 1864.

In 1866 a split occurred in the management of the Homœopathic College and the Hahnemann College was founded, Drs. Hering and Raue securing a charter therefor. In 1869 the

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new college became so prosperous as to absorb the old one and to occupy the old building on Filbert Street. As a teacher and lecturer Dr. Raue was interesting, accurate and concise.

Besides writing many articles for the societies and for the journals both in this country and abroad, he published in 1867 *Special Pathology and Diagnostics With Special Therapeutics.* A complete revision and fourth edition of this work he had completed as his last work only a little while before he broke down.

He edited the *Yearly Record of Homœopathic Literature* from 1870 to 1875, this being a library of extracts, reviews and notices of important articles appearing in the leading journals.

In the year 1889 *Psychology as a Natural Science* appeared, being the finished product of his life-long study and profound interest in that subject, manifested first in his early work referred to above.

Dr. Raue, since the death of Dr. Hering, has been looked upon as the Nestor of Philadelphia Homœopathy. Some others were older men, but to the old students he was as their father. He was a man of singularly genial disposition, and, though very patriarchal in appearance, he was always cheerful and young in his manner.

At his death a special meeting of the Homœopathic Medical Society of the County of Philadelphia was convened, and a series of resolutions were adopted, one of them calling for a memorial meeting in his memory. This meeting was held on October 17th in the large lecture-room of the college, both physicians and laymen being present. Addresses were made by Drs. Dudley, Guernsey and Knerr, and a poem was read by Dr. Bradford. A beautifully-bound engrossed copy of the minutes of the County Society was presented to the family of Dr. Raue by Dr. Dunning in behalf of the County Society.

Dr. Raue was a charter member of the Philadelphia County Homœopathic Medical Society, and also of the Pennsylvania State Society. He was also a member of the American Institute from 1869. He received honorary memberships from many societies at home and abroad.

His health had been failing for some months, but he continued at work, both in his practice and at his literary labors,

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until within a few weeks of his death. While at his son's home in the country he became more feeble, and desired to be brought to his home, where in a few days he passed away painlessly.

His remains were cremated, in accordance with his expressed wish, at Cheltenham, representatives of the societies and other friends being present.

His literary fame will rest mainly on his *Psychology as a Natural Science Applied to the Solution of Occult Psychic Phenomena*, and his new *Special Pathology and Diagnostics with Therapeutic Hints*. One of the strong men has left us.

Dr. John L. Ferson was born in Pittsburg, November 8, 1854, of Scotch ancestry. He died in the same city July 12, 1896. He was a graduate of the Pittsburg High School. He read medicine with Dr. W. H. Fulton, of Pittsburg, and graduated as an M.D. from the Hahnemann Medical College of Philadelphia in 1879, taking the first prize for scholarship, a gold medal, in a class of sixty-three members. In 1880 he located in Pittsburg, engaging in general practice. In 1885 he took a post-graduate course in the New York Post-Graduate Medical College, making special study of the diseases of women and of the organs of the chest.

Early in his life he had an attack of rheumatic fever, which left mitral difficulty. This had increased to such an extent that he felt it necessary to give up work as a general practitioner, and about two years before his death he took up special work on eye, ear, nose and throat.

The Doctor was a member of the American Institute of Homœopathy, of the Homœopathic Medical Society of the State, of the Homœopathic Medical Society of Allegheny County, and a member of the Staff of the Homœopathic Medical and Surgical Hospital of Pittsburg. He had been President of the County Society and a Vice-President of the State Society, and had contributed valuable articles to the TRANSACTIONS of these societies.

Of him a friend has said: "He was honored and respected by the profession and by all who knew him. He was a true Christian man; one who carried his religion into his daily life." He was an elder in the Presbyterian Church and a Sunday-School Superintendent.

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The Allegheny County Society passed a highly-eulogistic minute after his death.

He leaves a wife, who was Miss Lizzie Stevenson, and two children. He was buried at Sharon, Pa.

The following homœopathic physicians, not members of the Society, have died since our last meeting:

Dr. Mahlon H. Preston, of Norristown, born in 1839, and died October 2, 1895.

Dr. Frances Ida Henderson, of Titusville, Pa., died November 13, 1895.

Dr. David R. Posey, of Philadelphia, died February 3, 1896, in the sixty-seventh year of his age.

Dr. Ralph C. Smith, of 1434 Poplar Street, Philadelphia, died February 20, 1896, aged fifty-six years.

Dr. Henry C. Neff.

Dr. A. W. Stewart.

Respectfully submitted,

THOMAS S. DUNNING, M.D.,
Necrologist.

The Auditing Committee reported that it had examined the accounts of the Treasurer and found them correct. The report of the Committee was received, and it was discharged with the thanks of the Society.

The various bills incurred by the officers of the Society during the past year were read and directed to be paid.

On motion of the Treasurer, the following Committee was appointed to examine the correspondence received by him in reference to resignations, etc.: J. F. Cooper, M.D., Bushrod W. James, M.D., and Z. T. Miller, M.D.

REPORT OF THE COMMITTEE TO EXAMINE THE COMMUNICATIONS SENT TO THE TREASURER OF THE SOCIETY.

Your Committee to examine the correspondence in the Treasurer's hands, and report on the cases of members desiring to resign, respectfully offer that the resignations of Dr. T.

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L. MacDonald, of Washington, D. C., and Dr. H. J. Evans, of Baltimore, Md., residing out of the State, be accepted. Also, that Dr. Edward A. Wareham, who has been ill for several years, and has given up practice, have his dues of $10 remitted. Having paid over $50 in dues, and having been a member more than twenty-five years in good standing, we recommend that he be exonerated from further payment of dues. Also, Dr. B. B. Gumpert, who is one of our earliest members.

We recommend that, at their request, the names of Dr. W. C. Slough, of Emaus, Pa., and C. H. Hubbard, of Millville, N. J., be withdrawn from the roll of membership.

BUSHROD W. JAMES, M. D.,
Z. T. MILLER, M.D.,
J. F. COOPER, M.D.

On motion, the report of the Committee was adopted and the Committee discharged.

The following amendment to the By-Laws and Resolution was, on motion, adopted:

PHILADELPHIA, September 30, 1896.

To the Officers and Members of the Homœopathic Medical Society of the State of Pennsylvania:

The undersigned moves the adoption of the following amendment to the By-Laws, Article II., creating a new section, to be known as Section 2:

SECTION 2.—The members of the Board of Censors shall be elected to serve three years, one member to be elected each year. He shall enter upon his duties on the first day of January next succeeding their election.

Also the following resolution:

Resolved, That at the present meeting one member of the Board of Censors shall be elected to serve one year, one to serve two years, and one to serve three years, the length of their respective terms to be determined by the number of votes cast for each—the one receiving the highest number of votes to serve three years, the one receiving the next highest number of votes two years, etc. EDWARD M. GRAMM, M.D.

In reference to the paper presented by the Pharmacological

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Society of the Hahnemann Medical College, a motion was made that it be referred to the Committee on Publication for incorporation in the TRANSACTIONS of the Society, provided that it did not occupy more than fifty pages in them. An amendment was made to this motion referring the paper to the Committee for publication. After considerable discussion the amendment was carried and the matter left to the discretion of the Committee.

The second Vice-President appointed the following Committee on the President's Address: Pemberton Dudley, M.D., Isaac G. Smedley, M.D., and Z. T. Miller, M.D.

To the Homœopathic Medical Society of the State of Pennsylvania:

Your Committee on the Address of the President respectfully recommend as follows:

1. We recommend that the Executive Officers of the Society be authorized and instructed to take the necessary steps to have this Society incorporated under the laws of this Commonwealth.

2. We recommend that the Committee on Legislation be authorized and instructed to favor the enactment of laws providing for the appointment of medical experts *by the Courts*, as a substitute for the methods now in vogue, with a view to secure more able as well as more trustworthy aid in judicial proceedings.

3. We recommend that a vigorous and general effort be again made under the direction of the Committee on Legislation to secure State hospital care and homœopathic treatment for the insane of that large class of our citizens who employ the homœopathic method of medical treatment, on the same basis as this care and treatment is now provided for other citizens of this Commonwealth.

4. We recommend that if, in the opinion of the Executive Committee, the condition of the Society's finances will warrant the expenditure, each of the bureaus be authorized to print and distribute, prior to the next meeting, three papers to be discussed at said meeting. Provided, That this action shall not be construed as prohibiting the introduction of other papers, as at present.

PEMBERTON DUDLEY, M.D.,
ISAAC G. SMEDLEY, M.D.,
Z. T. MILLER, M.D.,
Committee.

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The first, second and third recommendations of the President were adopted, and the fourth was not adopted.

It was moved and carried that writers of papers furnish five copies of their papers for distribution among the members of the bureau for which they have written, in order to favor a more general and pointed discussion.

H. B. Ware, M.D., extended an invitation from the physicians of Scranton and vicinity to the Society to hold its next annual meeting at Scranton. On motion, the invitation was accepted.

On motion, the Treasurer was directed to pay the Recording Secretary twenty-five dollars for travelling expenses; also to pay Andrew Oliver ten dollars for services in connection with the meeting.

On motion of J. F. Cooper, M.D., the Publishing Committee was directed to deliver to the Carnegie Library a full set of the TRANSACTIONS of the Society as a donation.

The following amendment to the By-laws was offered by J. C. Guernsey, M.D., and it was, after being discussed, unanimously adopted :

Article XI., Section 1. All the minutes, motions and general doings of this Society shall be faithfully and accurately recorded by the Recording Secretary.

SEC. 2. The reading of the minutes for correction and adoption shall be the first order of business at each regular morning meeting of this Society.

J. C. Guernsey, M.D., and Hugh Pitcairn, M.D., then presented to the Society a minute-book for the use of the Recording Secretary.

The following officers were elected to serve for the ensuing year:

President, Z. T. Miller, M.D., Pittsburg.

First Vice-President, William H. Keim, M.D., Philadelphia.

Second Vice-President, Horace B. Ware, M.D., Scranton.

Recording Secretary, George B. Moreland, M.D., Pittsburg.

Corresponding Secretary, Edward M. Gramm, M.D., Philadelphia.

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Treasurer, J. F. Cooper, M.D., Allegheny.

Necrologist, Thomas L. Bradford, M.D., Philadelphia.

Censors, Ella D. Goff, M.D., Allegheny, to serve for three years.

C. W. Roberts, M.D., Scranton, to serve for two years.

F. Mortimer Lawrence, M.D., Philadelphia, to serve for one year.

The Committee on Damage Suits reported that it had drawn up a bill on the subject to present to the Legislature, and offered the bill to the Society as its report.

On motion, the report was received and adopted, and the bill referred to the Committee on Legislation for action.

The Committee on Hahnemann Monument Fund reported as follows:

REPORT OF COMMITTEE ON HAHNEMANN MONUMENT FUND.

Mr. President:

The Committee on Hahnemann Monument Fund begs leave through the chairman to make the following report. The chairman, on receiving notice of his appointment, at once appointed the following as members of the committee:

Drs. B. F. Betts, Philadelphia; Mary Branson, Philadelphia; S. G. A. Brown, Shippensburg; J. A. Bullard, Wilkesbarre; Edward E. Cranch, Erie; John J. Detwiller, Easton; Theo. J. Gramm, Philadelphia; W. A. Hassler, Allentown; J. E. Jones, West Chester; Daniel Karsner, Germantown; J. L. Dunn, Titusville; Hugh Pitcairn, Harrisburg; F. R. Schmucker, Reading; S. M. Rinehart, Allegheny; E. R. Gregg, Pittsburg; C. F. Bingaman, Pittsburg; Wm. Willets, Williamsport; J. C. Guernsey, Philadelphia.

Your Committee has canvassed the State and brought the matter of contributions to the fund before the physicians in such a manner that it is hoped much good may follow. How much money has been subscribed owing to this canvass it is not known, as contributions have been sent directly to the

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treasurer, Dr. Bushrod W. James. The Committee hopes that its efforts during the past year will bring larger returns in the future than have been realized during the present year of financial uncertainty and depression.

L. H. WILLARD,
Chairman.

BUSHROD W. JAMES, M.D., the Treasurer of the Hahnemann Monument Fund, presented his report as follows:

REPORT OF THE TREASURER OF THE HAHNEMANN STATUE FUND OF PENNSYLVANIA, September 29, 1896.

The status of the subscriptions in this State are about as follows:

Amount subscribed and paid, ...	$3534.00
Unpaid subscriptions, ...	995.00
Total subscribed, ...	$4529.00

The Monument is under construction, and about all the money thus far paid in has been expended upon the work.

The balance of the subscriptions are now needed in order to continue the work upon the Monument.

Additional subscriptions are needed and solicited.

Thus far, very few of the laity who receive the benefit of homœopathic treatment have subscribed toward the fund, owing, possibly, to the fact that it has not been properly presented to them.

Every member of the profession should subscribe at least ten dollars, while many who have not yet subscribed can and should give much more liberally than that.

Subscriptions and money can be sent direct to the State Treasurer of the Fund, or to the Treasurer of the Fund for the American Institute of Homœopathy, and it should come promptly.

All amounts have been passed over to Henry M. Smith, M.D.,

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New York, Treasurer of American Institute Committee on Hahnemann Statue Fund.

Respectfully submitted,

BUSHROD W. JAMES,

Treasurer of Hahn. Statue Fund for Penna.

On motion, the representatives of the press, who had so faithfully reported the doings of the Society, were thanked for their services.

On motion, the President of the Society was presented with a vote of thanks for his courtesy to the members during his term of office.

On motion, the Committee on Entertainment of the State Society received the thanks of the Society for the hospitality tendered to the visiting members.

A vote of thanks was given the authorities of the Hahnemann Medical College for the use of the college building for the meetings of the Society.

The President then announced the following Bureaus and Committees:

BUREAU OF MATERIA MEDICA.—Edward Cranch, M.D., Chairman; Associates, Drs. Chas. A. Ayers, John D. Boileau, Mary A. Cooke, W. K.Detwiller, W. G. Dietz, J. C. M. Drake, Thomas S. Dunning, D. P. Gerberich, George H. Haas, Augustus Korndœrfer, Sr., Caleb S. Middleton, Charles Mohr, C. S. Schwenk, W. A. Seibert, Samuel Starr, R. T. White.

BUREAU OF CLINICAL MEDICINE.—Oliver S. Haines, M.D., Chairman; Associates, Drs. Clarence Bartlett, W. Dod Bayley, Thomas H. Carmichael, James H. Closson, Percy H. Ealer, Silas Griffith, W. C. Goodno, John E. Harner, J. Richey Horner, William H. Keim, F. Mortimer Lawrence, E. C. Parsons, L. P. Posey, J. Herbert Reading, L. W. Reading, Thomas Reading, C. W. Roberts, Edward R. Snader, Maurice D. Youngman.

BUREAU OF SURGERY.—D. P. Maddux, M.D., Chairman; Associates, Drs. F. W. Brierly, J. W. Coolidge, Edward R. Gregg, J. Wyllis Hassler, Herbert L. Northrop, Roy C. Pitcairn, S. M. Rinehart, C. P. Seip, William G. Steele, Walter Strong, L. W.

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Thompson, Gustave A. Van Lennep, William B. Van Lennep, Carl V. Vischer, L. H. Willard.

BUREAU OF OBSTETRICS.—W. F. Edmundson, M.D., Chairman; Associates, Drs. Mary Branson, William H. H. Bull, J. H. Bullard, H. M. Bunting, G. Maxwell Christine, Ella D. Goff, Theodore J. Gramm, William D. King, J. B. McClelland, Edward W. Mercer, George B. Moreland, F. R. Schmucker, Pearl Starr.

BUREAU OF GYNÆCOLOGY.—John E. James, M.D., Chairman; Associates, Drs. B. Frank Betts, Millie J. Chapman, Margaret M. Hassler, C. H. Hofmann, Augustus Korndoerfer, Jr., J. W. Leckie, W. J. Martin, Eliza Lang McClure, Emma T. Schreiner, Isaac G. Smedley, J. H. Thompson, Julia Gould Waylan.

BUREAU OF PATHOLOGY AND PATHOLOGICAL ANATOMY.—P. Sharples Hall, M.D., Chairman; Associates, Drs. Joseph C. Guernsey, M. J. Holben, W. K. Ingersoll, Theodore M. Johnson, Joseph E. Jones, R. S. Marshall, C. R. Norton, Joseph R. Phillips, W. E. Rotzell.

BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.—William Spencer, M.D., Chairman; Associates, Drs. W. H. Bigler, W. W. Blair, H. Ballou Bryson, John Cooper, Peter Cooper, H. K. Hoy, Horace F. Ivins, B. W. James, H. I. Jessup, Lyttleton Lyon Lazear, Charles H. Lee, W. H. Lee, F. W. Messervè, Henry F. Schantz, Isaac G. Shallcross, George W. Stewart, Charles M. Thomas, Horace B. Ware, Harry S. Weaver.

BUREAU OF PÆDOLOGY.—William H. Cooper, M.D., Chairman; Associates, Drs. Mary Brewer, James H. Closson, Sarah J. Coe, Theodore P. Gittens, E. H. Hill, D. C. Kline, F. W. Lange, Anna M. Marshall, J. Nicholas Mitchell, Robert Murdock, T. Ellwood Parker, C. W. Perkins, Theodore Sureth, Matthew S. Williamson, C. D. Yocum.

BUREAU OF SANITARY SCIENCE.—J. H. McClelland, M.D., Chairman; Associates, Drs. A. W. Baily, A. P. Bowie, F. W. Burlingame, Anna C. Clarke, J. F. Cooper, Isaac Crowther, Pemberton Dudley, Irwin B. Gilbert, H. F. Heilner, J. H. Helfrich, Charles W. Karsner, Edmund H. Kase, Duncan Macfarlan, Hugh Pitcairn.

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COMMITTEE ON ORGANIZATION, REGISTRATION AND STATISTICS.—George B. Moreland, M.D., Chairman; Associates, Drs. J. F. Cooper, Edward M. Gramm.

COMMITTEE ON LEGISLATION.—H. C. Chisolm, M.D., Chairman; Associates, Drs. Clarence Bartlett, William K. Brown, Edw. Cranch, Isaac Crowther, W. G. Dietz, Pemberton Dudley, D. P. Gerberich, Edward M. Gramm, Joseph C. Guernsey, W. A. Hassler, John E. James, Joseph E. Jones, Charles W. Karsner, Edmund H. Kase, Wm. H. Keim, August Korndœrfer, Sr., D. P. Maddux, W. J. Martin, J. H. McClelland, C. S. Middleton, Charles Mohr, Hugh Pitcairn, J. H. Reading, H. F. Schantz, C. P. Seip, Isaac G. Smedley, W. B. Van Lennep, H. B. Ware, L. H. Willard.

COMMITTEE ON PUBLICATION.—Edward M. Gramm, M.D., Chairman; Associates, Drs. J. F. Cooper, George B. Moreland.

COMMITTEE ON HAHNEMANN MONUMENT.—W. J. Martin, M.D., Chairman; Drs. George F. Baier, A. P. Bowie, Francis W. Boyer, S. E. Burchfield, J. C. Merle Drake, J. Ely, G. W. Gregory, John E. Harner, F. E. Harpel, L. K. Heath, H. K. Hoy, Thomas A. Irwin, Bushrod W. James, Joseph E. Jones, Theodore M. Johnson, E. N. Leake, Charles H. Lee, J. H. McClelland, S. B. Moon, E. C. Parsons, Hugh Pitcairn, E. B. Rossiter, W. A. Seibert, F. J. Slough, William Willets.

DELEGATES TO AMERICAN INSTITUTE OF HOMŒOPATHY.—Drs. Pemberton Dudley, J. H. McClelland, Wm. B. Van Lennep.

DELEGATE TO SOUTHERN INSTITUTE OF HOMŒOPATHY.—Drs. Z. T. Miller, Millie J. Chapman, J. Arthur Bullard.

DELEGATES TO NEW JERSEY STATE SOCIETY.—Drs. Augustus Korndœrfer, Sr., W. S. Bigelow, Clarence Bartlett.

DELEGATES TO NEW YORK STATE SOCIETY.—Drs. W. H. Keim, H. B. Ware, L. H. Willard.

DELEGATES TO OHIO STATE SOCIETY.—Drs. Edward Cranch, C. H. Hofmann, Carl V. Vischer.

DELEGATES TO MARYLAND STATE SOCIETY.—Drs. G. Maxwell Christine, Edward M. Gramm, Wm. A. Haman.

DELEGATES TO DELAWARE STATE SOCIETY.—Drs. W. C. Goodno, D. P. Maddux, I. G. Smedley.

INTERSTATE COMMITTEE OF AMERICAN INSTITUTE OF HOMŒOPATHY.—Drs. Charles Mohr, E. R. Gregg.

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OFFICERS OF THE SOCIETY FROM ITS ORGANIZATION TO THE PRESENT TIME.

SESSION OF 1866.

J. B. WOOD, M.D., President.
J. H. P. FROST, M.D., First Vice-President.
J. C. BURGHER, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
D. COWLEY, M.D., Treasurer.

SESSION OF 1867.

W. WILLIAMSON, M.D., President.
J. H. MARSDEN, M.D., First Vice-President.
W. J. BLAKELY, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D, Corresponding Secretary.
H. H. HOFMANN, M.D., Treasurer.

SESSION OF 1868.

C. PRESTON. M.D., President.
H. H. HOFMANN, M.D., First Vice-President.
J. J. DETWILLER, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
W. M. WILLIAMSON, M.D., Treasurer.

SESSION OF 1869.

This session was presided over by Walter Williamson, M.D., in the absence of the President and Vice-President, and by special resolution adopted at the commencement of that session, the officers of 1870 were elected immediately prior to the adjournment of the meeting.

SESSION OF 1870.

[*Held in Erie, June 3 and 4, 1870.*]

O. B. GAUSE, M.D., President.
C. A. STEVENS, M.D., First Vice-President.
J. H. McCLELLAND, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
W. J. BLAKELY, M.D., Treasurer.

SESSION OF 1871.

[*Held in Harrisburg, February 1 and 2, 1871.*]

M. COTE, M.D., President.
R. FAULKNER, M.D., First Vice-President.
H. M. LOGEE, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
O. B. GAUSE, M.D., Treasurer.

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SESSION OF 1872.

[*Held in Harrisburg, February 6 and 7, 1872.*]

J. H. MARSDEN, M.D., President.
H. N. GUERNSEY, M.D., First Vice-President.
S. F. CHARLTON, M.D., Second Vice-President.
B. W. JAMES, M.D., Recording Secretary.
R. J. McCLATCHEY, M.D., Corresponding Secretary.
O. B. GAUSE, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1873.

[*Held in Harrisburg, February 6 and 7, 1873.*]

B. W. JAMES, M.D., President.
M. PRESTON, M.D., First Vice-President.
J. C. BURGHER, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
O. B. GAUSE, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1873.

[*Held in Harrisburg, October 1 and 2, 1873.*]

J. F. COOPER, M.D., President.
M. FRIESE, M.D., First Vice-President.
H. R. FETTERHOFF, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
R. J. McCLATCHEY, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1874.

[*Held in Philadelphia, October 7 and 8, 1874.*]

C. A. STEVENS, M.D., President.
I. LEFEVER, M.D., First Vice-President.
W. F. SPETH, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
R. J. McCLATCHEY, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1875.

[*Held in Pittsburg, October 13 and 14, 1875.*]

R. J. McCLATCHEY, M.D., President.
J. E. JONES, M.D., First Vice-President.
H. N. MARTIN, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
P. DUDLEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

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SESSION OF 1876.

J. E. JONES, M.D., President.
J. C. BURGHER, M.D., First Vice-President.
J. E. JAMES, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1877.

J. C. BURGHER, M.D., President.
L. H. WILLARD, M.D., First Vice-President.
J. E. JAMES, M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1878.

[*Held in Pittsburg, September* 25 *to* 28, 1878.]

H. N. GUERNSEY, M.D., President.
W. R. CHILDS, M.D., First Vice-President.
A. KORNDŒRFER, Sr., M.D., Second Vice-President.
M. M. WALKER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1879.

[*Held in Cresson, September* 2 *and* 3, 1879.]

L. H. WILLARD, M.D., President.
M. M. WALKER, M.D., First Vice-President.
L. M. ROSSEAU, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
J. C. GUERNSEY, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1880.

[*Held in Easton, September* 8 *and* 9, 1880.]

J. K. LEE, M.D., President.
H. DETWILLER, M.D., First Vice-President.
J. WESLEY ALLEN, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

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SESSION OF 1881.

[*Held in West Chester, September* 20 *to* 22, 1881.]

J. H. McCLELLAND, M.D., President.
B. F. BETTS, M.D., First Vice-President.
J. J. DETWILLER, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1882.

[*Held in Altoona, September* 5 *to* 7, 1882.]

J. C. MORGAN, M.D., President.
PEMBERTON DUDLEY, M.D., First Vice-President.
J. B. WOOD, M.D., Second Vice-President.
Z. T. MILLER, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1883.

[*Held in Philadelphia, September* 18 *to* 20, 1883.]

P. DUDLEY, M.D., President.
HUGH PITCAIRN, M.D., First Vice-President.
C. F. BINGAMAN, M.D., Second Vice-President.
T. M. STRONG, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1884.

[*Held in Pittsburg, September* 16 *to* 18, 1884.]

W. R. CHILDS, M.D., President.
C. MOHR, M.D., First Vice-President.
H. DETWILLER, M.D., Second Vice-President.
C. BARTLETT, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
M. M. WALKER, M.D., Necrologist.

SESSION OF 1885.

[*Held in Philadelphia, September* 23 *to* 25, 1885.]

JOHN E. JAMES, M.D., President.
D. COWLEY, M.D., First Vice-President.
J. K. LEE, M.D., Second Vice-President.
C. BARTLETT, M.D., Recording Secretary.
R. E. CARUTHERS, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

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SESSION OF 1886.

[*Held in Philadelphia, September* 20 *to* 23, 1886.]

D. COWLEY, M.D., President.
W. H. BIGLER, M.D., First Vice-President.
J. R. READING, M.D., Second Vice-President.
HORACE F. IVINS, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1887.

[*Held in Pittsburg, September* 20 *to* 22, 1887.]

A. R. THOMAS, M.D., President.
W. J. MARTIN, M.D., First Vice-President.
EDW. CRANCH, M.D., Second Vice-President.
HORACE F. IVINS, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1888.

[*Held in Philadelphia, September* 18 *to* 20, 1888.]

HUGH PITCAIRN, M.D., President.
W. B. TRITES, M.D., First Vice-President.
C. F. BINGAMAN, M.D., Second Vice-President.
J. H. CLOSSON, M.D., Recording Secretary.
CLARENCE BARTLETT, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.

SESSION OF 1889.

[*Held in Pittsburg, September* 17 *and* 18, 1889.]

W. B. TRITES, M.D., President.
C. F. BINGAMAN, M.D., First Vice-President.
JOHN MALIN, M.D., Second Vice-President.
J. H. CLOSSON, M.D., Recording Secretary.
E. R. SNADER, M.D., Corresponding Secretary.
J F. COOPER, M.D., Treasurer.
W. R. CHILDS, M.D., Necrologist.
J. RICHEY HORNER, M.D., Vice-Necrologist.

SESSION OF 1890.

[*Held in Philadelphia, September* 17 *to* 19, 1890.]

C. F. BINGAMAN, M.D., President.
C. S. MIDDLETON, M.D., First Vice-President.
C. H. LEE, M.D., Second Vice-President.
J. RICHEY HORNER, M.D., Recording Secretary.
E. R. SNADER, M.D., Corresponding Secretary.
J. F. COOPER, M.D., Treasurer.
W. J. MARTIN, M.D., Necrologist.

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SESSION of 1891.

[*Held in Pittsburg, September* 15 *to* 17, 1891.]

AUGUSTUS KORNDŒRFER, Sr., M.D., President.
E. C. PARSONS, M.D., First Vice-President.
M. J. CHAPMAN, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
E. R. SNADER, M.D., Corresponding Secretary.
J. RICHEY HORNER, M.D., Recording Secretary.
W. J. MARTIN, M.D., Necrologist.

SESSION OF 1892.

[*Held in Philadelphia, September* 14 *to* 16, 1892.]

E. C. PARSONS, M.D., President.
F. R. SCHMUCKER, M.D., First Vice-President.
SARAH J. COE, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
E. R. SNADER, M.D., Corresponding Secretary.
J. RICHEY HORNER, M.D., Recording Secretary.
W. J. MARTIN, M.D., Necrologist.

SESSION OF 1893.

[*Held in Pittsburg, September* 19 *to* 21, 1893.]

J. C. GUERNSEY, M.D., President.
SARAH J. COE, M.D., First Vice-President.
J. L. FERSON, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
E. R. SNADER, M.D., Corresponding Secretary.
J. RICHEY HORNER, M.D., Recording Secretary.
W. J. MARTIN, M.D., Necrologist.

SESSION OF 1894.

[*Held in Philadelphia, September* 19 *to* 21, 1894.]

CALEB S. MIDDLETON, M.D., President.
Z. T. MILLER, M.D., First Vice-President.
ELIZA LANG McCLURE, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
J. RICHEY HORNER, M.D., Recording Secretary.
EDWARD R. SNADER, M.D., Corresponding Secretary.
W. J. MARTIN, M.D., Necrologist.

SESSION OF 1895.

[*Held in Pittsburg, September* 17 *to* 19, 1895.]

W. J. MARTIN, M.D., President.
M. M. WALKER, M.D., First Vice-President.
A. P. BOWIE, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
J. RICHEY HORNER, M.D., Corresponding Secretary.
EDWARD M. GRAMM, M.D., Recording Secretary.
T. S. DUNNING, M.D., Necrologist.

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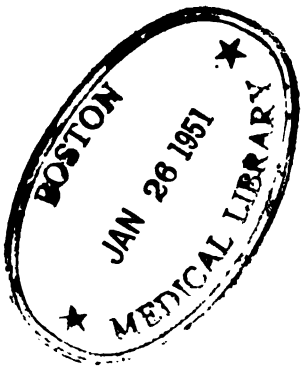
SESSION OF 1896.

[*Held in Philadelphia, September* 29, 30, *October* 1, 1896.]

W. W. VAN BAUN, M.D., President.
R. W. McCLELLAND, M.D., First Vice-President.
E. R. SNADER, M.D., Second Vice-President.
J. F. COOPER, M.D., Treasurer.
GEORGE B. MORELAND, M.D., Recording Secretary.
EDWARD M. GRAMM, M.D., Corresponding Secretary.
T. S. DUNNING, M.D., Necrologist.



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CONSTITUTION AND BY-LAWS.

CONSTITUTION.

ARTICLE I.—NAME AND OBJECT.

THIS Association shall be known as the Homœopathic Medical Society of the State of Pennsylvania.

Its object is the advancement of medical science.

ARTICLE II.—MEMBERS.

This Society shall be composed of active, honorary and corresponding members, who shall be chosen in conformity with the By-Laws.

ARTICLE III.—OFFICERS.

The officers of this Society shall be a President, two Vice-Presidents, a Recording Secretary, a Corresponding Secretary, a Treasurer, a Necrologist and a Board of Censors, consisting of three members, who shall be chosen at such time, and in such manner and for such a period, and shall perform such duties as the By-Laws may direct.

ARTICLE IV.—AMENDMENT.

The Constitution may be altered or amended by a vote of two-thirds of the members present at the annual meeting; *provided*, that notice of such intended alteration or amendment shall have been given to the Society, in writing, at the annual meeting next preceding.

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BY-LAWS.

ARTICLE I.—Meetings.

Section 1. The annual meeting of this Society shall be held at ten A.M., at the time and place decided upon at the annual session next preceding.

Nine members shall constitute a quorum for the transaction of business.

Sec. 2. The elected officers of the Society shall have power to direct such other meetings to be held as they may judge advisable.

Sec. 3. Should any occasion arise making it advisable or necessary to change the time and place of meeting agreed upon at the previous annual meeting, the same may be done by a vote of two-thirds of the officers of the Society, with the concurrence of the Committee of Arrangements.

ARTICLE II.—Officers.

Section 1. The officers shall be elected by ballot at each annual meeting of the Society, and shall enter upon their respective duties on the first day of January next succeeding their election.

Sec. 2. The members of the Board of Censors shall be elected to serve three years, one member to be elected each year. They shall enter upon their duties on the first day of January next succeeding their election.

ARTICLE III.—Duties of Officers.

Section 1. The President shall preside at the meetings of the Society, preserve order therein, put questions, announce decisions and appoint committees not otherwise ordered. He shall deliver an address during the first day of the session.

Sec. 2. The Vice-Presidents, in the order of their election, shall perform the duties of the President in his absence.

Sec. 3. The Recording Secretary shall keep a record of all the proceedings and resolutions, and of all discussions that may occur in the Society; authenticate, by his signature, all papers

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and acts of the Society, when the occasion requires it, and bring before the Society any business needing its action not otherwise presented.

SEC. 4. The Corresponding Secretary shall receive and preserve all letters addressed directly to the Society; open and maintain such correspondence as shall tend to advance its interests; give at least two weeks' notice to the members of all meetings of the Society; keep a record of all members, with the date of admission of each; present all communications to the Society; notify all committees of their appointment and of the business referred to them, and notify all members of their election. He shall be *ex officio* Chairman of the Bureau of Organization, Registration and Statistics.

SEC. 5. The Treasurer shall notify, annually, all members of arrearages, collect all money belonging to the Society, and make all disbursements ordered by the Society. He shall furnish, at each annual meeting, a written report of his receipts and expenditures, and a statement of the condition of the finances.

SEC. 6. The Necrologist shall, upon the death of a member of the Society, prepare a suitable obituary and present it to the Society; he shall also forward a copy, properly engrossed, to the family of the deceased member, if so ordered by the Society.

The report of the Necrologist shall be presented in connection with the report and papers of the Bureau of Organization, Registration and Statistics.

SEC. 7. The Censors shall receive and examine the credentials of candidates for membership, and shall report to the Society, for election, such as may be found to be properly qualified.

Their report can be made in its regular order, or at the close of the report of any bureau.

ARTICLE IV.—MEMBERSHIP.

SECTION 1. *Active.*—A candidate for active membership may present to the Board of Censors a written application, signed by himself, accompanied by a certificate from two members of the Society in good standing, that the applicant has received

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the degree of Doctor of Medicine from an incorporated medical college, that he subscribes to the doctrines of *Similia Similibus Curantur*, and that he sustains a good moral character. If found qualified, he may be elected a member. He shall not, however, be considered a member until he has paid the first year's dues and signed the Constitution, either in person or by proxy.

Any active member removing from the State wishing to retain his membership shall notify the Society to that effect; otherwise his name shall be dropped from the roll.

Any active member who fails either to attend the annual meeting or to send a paper once in five years, or to pay his dues, shall, upon vote of the Society, be dropped from membership.

Any member who shall be unable to comply with the requirements of this Society may be continued as an active member, without payment of dues, by vote of the Society.

SEC. 2. *Honorary.*—Any Homœopathic physician, not a resident of Pennsylvania, who, from his superior attainments, may be judged worthy, may be elected an honorary member at any annual meeting, but no more than two shall be elected in one year.

Such honorary members shall have all the privileges of members except the right to vote and to hold office.

SEC. 3. *Corresponding.*—Any Homœopathic physician residing outside of the United States may be elected a corresponding member at any annual meeting, but not more than two shall be elected in one year.

Such corresponding members shall have all the privileges of members except the right to vote and hold office.

ARTICLE V.—DUES.

Active members shall pay annually, in advance, the sum of five dollars towards defraying the expenses of the Society.

The published proceedings of the Society will be furnished only to those members who are not in arrears.

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ARTICLE VI.—Bureaus and Committees.

Section 1. The following bureaus shall be appointed as hereinafter provided:

One of Materia Medica and Provings.

One of Homœopathic Institutes and Clinical Medicine.

One of Surgery.

One of Obstetrics.

One of Gynæcology.

One of Pathology and Pathological Anatomy.

One of Ophthalmology, Otology and Laryngology.

One of Pædology.

One of Sanitary Science.

One of Organization, Registration and Statistics.

Sec. 2. Each bureau shall be composed of not less than five members, and no member shall be placed on more than one bureau in one year.

Sec. 3. The bureaus shall report in order of rotation each succeeding year, except that the report of the Bureau of Materia Medica shall always be a special order of business at the opening of the afternoon session of the second day of the Society meeting.

Sec. 4. The Bureau of Organization, Registration and Statistics shall receive all credentials of delegates to the Society; receive and preserve all reports from local or State societies, colleges, and other institutions; keep a record of the number of members admitted and withdrawn from the Society; solicit an exchange of publications with other State societies, and perform such other duties as may be directed by the Society. From these data the annual report of the bureau shall be prepared.

Sec. 5. Immediately upon the close of the report of a bureau, the President shall appoint a chairman for the ensuing year; and the chairman so appointed shall, in conjunction with the President, select his associates, and the list of members of the bureaus shall be announced before the close of the session.

Sec. 6. If any member of a bureau shall resign or decline to serve, the chairman of the bureau shall fill the vacancy by appointment, and notify the Corresponding Secretary of the fact.

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SEC. 7. The following Standing Committees shall be appointed, as hereinafter provided for:

A Legislative Committee.

A Publishing Committee.

SEC. 8. Each of these committees shall consist of at least three members, to be appointed by the President.

SEC. 9. The Legislative Committee shall give special attention to all legislation involving the interests of the Society.

SEC. 10. The Publishing Committee shall publish and issue the TRANSACTIONS to all who are entitled to receive them within three months from the date of the meeting, unless otherwise directed by the Society at its annual meeting.

The Recording and Corresponding Secretaries and the Treasurer shall constitute this committee, but the number of members may be increased at the discretion of the Society.

ARTICLE VII.—PAPERS AND DISCUSSIONS.

SECTION 1. Each paper presented to this Society shall be through its appropriate bureau. All papers to be presented by any bureau shall be in the hands of the chairman thereof at the opening of the session. All papers shall be subject to the approval and revision of the Committee of Publication. No report or paper will be received by the Society in an incomplete or unfinished condition, and no paper shall be published as part of the TRANSACTIONS which has been published previous to its presentation. No paper shall occupy more than fifteen minutes in the reading, unless the time be extended by vote of the Society.

SEC. 2. Any paper may be published in a medical journal at any time subsequent to its presentation, provided that it be prepared in duplicate, and the original retained in the custody of the Committee of Publication.

SEC. 3. All communications read before the Society shall become its property; but no paper shall be published as part of the TRANSACTIONS of the Society without its sanction.

SEC. 4. All discussions shall be strictly confined to the subject of the paper or report, and each speaker shall be limited to a

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speech of ten minutes; and to one of five minutes if he speaks a second time; and no excess of time shall be allowed except by consent of the Society. The reader of the paper shall be allowed ten minutes at the close of the discussion.

SEC. 5. Each county or local society shall be invited to prepare and discuss, during the year, a paper upon some medical subject and present it to the Society, at its annual meeting, through its appropriate bureau.

ARTICLE VIII.—AMENDMENTS.

These By-Laws may be altered or amended by a vote of two-thirds of the members present at any annual meeting.

ARTICLE IX.—SEAL.

SECTION 1. This Society shall have and use one common seal, with a suitable device and inscription.

SEC. 2. This seal shall be placed in the custody of the Corresponding Secretary.

ARTICLE X.—SENIOR MEMBERS—CODE OF ETHICS.

SECTION 1. All members of this Society who have maintained twenty-one consecutive years of membership shall be considered senior members, and the names of such members shall be printed in capital letters.

SEC. 2. The Code of Ethics of the American Institute of Homœopathy is hereby adopted by this Society.

SEC. 3. All complaints relating to a violation of the Code of Ethics shall be referred to the Board of Seniors for consideration and adjustment, and its decision shall be final.

ARTICLE XI.

SECTION 1. All the minutes, motions and general doings of this Society shall be faithfully and accurately recorded by the Recording Secretary.

SEC. 2. The reading of the minutes for correction and adoption shall be the first order of business at each regular morning meeting of this Society.

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ORDER OF BUSINESS.

1. Calling the meeting to order.
2. Address by the President.
3. Roll-call and correction of list of members.
4. Appointment of Committee on President's Address.
5. Report of Treasurer.
6. Appointment of Auditing Committee.
7. Report of Corresponding Secretary.
8. Reports of Committees.
9. Reports of Censors and election of members.
10. Reports of Bureaus.
11. Unfinished business.
12. New business.
13. Election of officers.
14. Announcements of bureaus and committees.
15. Adjournment.

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LIST OF MEMBERS.

1892—Baier, George F., M.D., Norwood.
1889—Baily, A. W., M.D., 1618 Pacific Ave., Atlantic City, N. J.
1896—Baker, Albra W., M.D., Emporium.
1881—Bartlett, Clarence, M.D., 1506 Arch Street, Philadelphia.
1889—Bayley, Weston D., M.D., 1434 Poplar St., Philadelphia.
1875—BETTS, B. F., M.D., 1609 Girard Avenue, Philadelphia.
1886—Bier, P. A., M.D., 4200 Butler Street, Pittsburg.
1892—Bigelow, W. S., M.D., Phillipsburg.
1872—BIGLER, W. H., M.D., 1524 Arch Street, Philadelphia.
1873—BINGAMAN, C. F., M.D., 922 Penn Avenue, Pittsburg.
1896—Birch, J. P., M.D., 3801 Powelton Avenue, Philadelphia.
1894—Bittner, Albert Jacob, M.D., Allentown.
1892—Blair, W. W., M.D., 400 Penn Avenue, Pittsburg.
1892—Boileau, John D., M.D., 804 W. Lehigh Ave., Philadelphia.
1892—Books, B. F., M.D., 1117 Twelfth Avenue, Altoona.
1872—BOWIE, A. P., M.D., 372 Main Street, Uniontown.
1884—Boyd, G. S., M.D., Beaver Falls.
1880—Boyd, J. S., M.D., New Brighton.
1882—Boyer, Francis W., M.D., Pottsville.
1894—Bradford, Thomas Lindsley, M.D., 1862 Frankford Avenue, Philadelphia.
1883—Branson, Mary, M.D., 1719 Arch Street, Philadelphia.
1896—Brewer, Mary, M.D., 330 E. Chelten Ave., Gtn., Philadelphia.
1895—Brewster, F. D., M.D., Scranton.
1895—Brierly, F. Walter, M.D., 2221 N. 21st Street, Philadelphia.
1891—Brown, C. H., M.D., 1824 Diamond Street, Philadelphia.
1895—Brown, Lincoln S., M.D., 636 Penn Avenue, Pittsburg.
1894—Brown, S. G. A., M.D., Shippensburg.
1891—Brown, William K., M.D., 1311 N. Broad St., Philadelphia.
1893—Bryson, H. Ballou, M.D., 524 Penn Avenue, Pittsburg.
1885—Buchman, Francis, M.D., 1609 S. Broad St., Philadelphia.
1886—Bulick, T. M., M.D., 115 South Street, Harrisburg.
1892—Bull, William H. H., M.D., Atlantic City, N. J.
1877—Bullard, J. A., M.D., 130 S. Main Street, Wilkesbarre.

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1881—Bunting, H. M., M.D., 521 Swede Street, Norristown.
1888—Burchfield, S. E., M.D., 803 Ligonier Street, Latrobe.
1891—Burlingame, F. W., M.D., 423 Fifth Avenue, McKeesport.
1866—BURGHER, J. C., M.D., 960 Penn Avenue, Pittsburg.
1896—Caley, Joseph M., M.D., 1513 Green Street, Philadelphia.
1888—Carmichael, T. H., M.D., 5530 Germantown Avenue, Philadelphia.
1875—CHAPMAN, MILLIE J., M.D., 804 Penn Ave., Pittsburg.
1888—Chisolm, H. C., M.D., 528 Penn Street, Huntingdon.
1891—Cleeland, J. S., M.D., 5936 Penn Avenue, Pittsburg.
1889—Clarke, Anna C., M.D., 426 Adams Avenue, Scranton.
1893—Clark, George H., M.D., 4 Walnut Lane, Germantown, Philadelphia.
1886—Closson, J. H., M.D., 53 W. Chelten Ave., Germantown, Phila.
1894—Conarroe, Thomas H., M.D., 872 N. 26th Street, Philadelphia.
1883—Coe, Sarah J., M.D., 92 N. Franklin Street, Wilkesbarre.
1895—Cook, W. C., M.D., 327 Grandview Avenue, Pittsburg.
1894—Cooke, Mary A., M.D., 2113 N. 18th Street, Philadelphia.
1889—Coolidge, J. W., M.D., 334 Washington Ave., Scranton.
1889—Cooper, Isaac, M.D., 194 S. Broad Street, Trenton, N. J.
1887—Cooper, John, M.D., 54 Arch Street, Allegheny.
1866—COOPER, J. F., M.D., 105 Arch Street, Allegheny.
1894—Cooper, Peter, M.D., 502 Delaware Avenue, Wilmington, Del.
1895—Cooper, Wm. H., M.D., Oakmont.
1887—Cowley, William, M.D., 6412 Penn Avenue, Pittsburg.
1882—Cranch, Edw., M.D., 109 W. Ninth Street, Erie.
1885—Crowther, Isaac, M.D., Chester.
1891—Davis, B. L., M.D., Bellevue.
1866—DETWILLER, JOHN J., M.D., 52 Center Square, Easton.
1893—Detwiller, W. K., M.D., Easton.
1886—Dietz, W. G., M.D., 21 N. Vine Street, Hazleton.
1878—Dinsmore, S. W. S., M.D., Sharpsburg.
1895—Doyle, H. H., M.D., 485 Fifth Avenue, Pittsburg.
1891—Drake, J. C. Merle, M.D., 720 Sassafras Street, Erie.
1867—DUDLEY, PEMBERTON, M.D., 1405 N. 16th St., Phila.
1878—Duff, P. S., M.D., Great Belt.
1882—Du Four, W. M., M.D., 755 W. Third Street, Williamsport.
1881—Dunning, T. S., M.D., 1328 N. 15th Street, Philadelphia.
1893—Ealer, Percy H., M.D., 815 N. 24th Street, Philadelphia.
1891—Ely, J., M.D., Washington.
1873—EDMUNDSON, W. F., M.D., 1321 Fifth Avenue, Pittsburg.
1896—Esrey, L. K., M.D., 1642 Pine Street, Philadelphia.

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1882—Evans, H. J., M.D., Northeast cor. Carey and Fayette Streets, Baltimore, Md.
1895—Fitz, W. H. A., M.D., 819 N. 25th Street, Philadelphia.
1892—Flint, Harvey E., M.D., West 11th Street, Erie.
1892—Flint, John F., M.D., 1112 Peach Street, Erie.
1884—Fleming, R. K., M.D., 6224 Station Street, Pittsburg.
1873—FULTON, H. W., M.D., 5949 Penn Avenue, Pittsburg.
1889—Gangloff, Charles, M.D., 6 S. Main Street, Pittsburg.
1892—Gerberich, D. P., M.D., Lebanon.
1886—Gerhart, Jos. M., M.D., 1127 Mt. Vernon St., Philadelphia.
1879—Getze, G. M., M.D., Tarentum.
1891—Gilbert, Irwin B., M.D., 2027 Columbia Ave., Philadelphia.
1885—Giles, J. William, M.D., Nyack, N. Y.
1894—Gittens, Theodore P., M.D., 1716 Diamond St., Philadelphia.
1891—Goff, Ella D., M.D., 41 N. Diamond Street, Allegheny.
1875—GOODNO, W. C., M.D., 1724 Chestnut Street, Philadelphia.
1883—Gramm, Edward M., M.D., 1433 Girard Ave., Philadelphia.
1867—GRAMM, G. E., M.D., Ardmore.
1883—Gramm, Theo. J., M.D., 846 N. Broad St., Philadelphia.
1895—Gregg, Edw. R., M.D., 276 Shady Avenue, Pittsburg.
1889—Gregory, G. W., M.D., Troy.
1888—Griffith, Louis B., M.D., 2526 Ridge Ave., Philadelphia.
1881—Griffith, Silas, M.D., 1431 Girard Avenue, Philadelphia.
1877—Griffith, W. M., M.D., 2035 Ridge Avenue, Philadelphia.
1886—Grimes, Thomas H., M.D., Sewickley.
1874—GUERNSEY, J. C., M.D., 1923 Chestnut Street, Philadelphia.
1867—GUMPERT, B. BARTON, M.D., 840 Franklin St., Phila.
1886—Gundlach, F. C., M.D., 1722 Sarah Street, Pittsburg.
1894—Haas, George H., M.D., Allentown.
1885—Haines, O. S., M.D., 137 N. 15th Street, Philadelphia.
1896—Hall, P. Sharples, M.D., 1604 Arch Street, Philadelphia.
1895—Hall, W. D., M.D., Altoona.
1887—Haman, W. A., M.D., 122 N. 8th Street, Reading.
1883—Hancock, Jos., M.D., 1639 Columbia Ave., Philadelphia.
1891—Harpel, F. E., M.D., Danville.
1888—Harner, John E., M.D., 117 S. 5th Street, Reading.
1884—Harris, D. R., M.D., 41 N. Jefferson Street, New Castle.
1892—Hassler, J. Wyllis, M.D., 729 N. 17th St., Philadelphia.
1892—Hassler, M. Margaret, M.D., Allentown.
1883—Hassler, W. A., M.D., 105 N. 8th Street, Allentown.
1893—Heath, L. R., M.D., Mercer.
1895—Heilner, H. F., M.D., Scranton.

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1883—Helfrich, J. H., M.D., Allentown.
1892—Heritage, A. C., M.D., Jenkintown.
1873—HERRON, C. D., M.D., 3505 Butler Street, Pittsburg.
1892—Hill, E. H., M.D., Tunkhannock.
1882—Hofmann, C. H., M.D., 510 S. Highland Avenue, Pittsburg.
1883—Holben, M. J., M.D., Slatington.
1892—Holsberg, W. H., M.D., Lebanon.
1883—Horner, J. Richey, M.D., 79 Arch Street, Allegheny.
1889—Hoy, H. K., M.D., 1203 Fourteenth Street, Altoona.
1880—Humes, J. R., M.D., Hollidaysburg.
1886—Ingersoll, W. K., M.D., 4008 Chestnut St., Philadelphia.
1892—Irvin, Thomas A., M.D., Franklin.
1882—Ivins, Horace F., M.D., 1621 Chestnut St., Philadelphia.
1866—JAMES, BUSHROD W., M.D., 1719 Green Street, Phila.
1867—JAMES, JOHN E., M.D., 1521 Arch Street, Philadelphia.
1889—Jamison, M. R., M.D., Greensburg.
1892—Jessup, H. I., M.D., 1829 Arch Street, Philadelphia.
1881—Johnson, Theodore M., M.D., 200 Susquehanna Ave., Pittston.
1869—JONES, JOS. E., M.D., 113 S. High St., West Chester.
1892—Karsner, Charles W., M.D., 316 S. 12th St., Philadelphia.
1881—Karsner, Daniel, M.D., 205 Tulpehocken Street, Germantown.
1889—Kase, Edmund H., M.D., 1323 Girard Ave., Philadelphia.
1891—Kaufman, John, M.D., Hazleton.
1896—Keelor, J. G., M.D., 48th and Baltimore Ave., Philadelphia.
1885—Keim, William H., M.D., 2015 Ridge Ave., Philadelphia.
1894—Kehler, B. Frank, M.D., 1708 N. 8th Street, Philadelphia.
1884—King, W. D., M.D., 1046 Fifth Avenue, Pittsburg.
1892—Kistler, A. L., M.D., Allentown.
1891—Kline, D. C., M.D., 209 S. 5th Street, Reading.
1891—Knauer, J. C., M.D., 233 S. 9th Street, Reading.
1877—Knerr, C. B., M.D., 1137 Spruce Street, Philadelphia.
1872—KORNDŒRFER, AUGUSTUS, Sr., M.D., 1728 Green Street, Philadelphia.
1896—Korndœrfer, Augustus, Jr., M.D., 1728 Green St., Phila.
1896—Krusen, Edward A., M.D., Collegeville.
1889—Lange, F. W., M.D., 429 Lackawanna Avenue, Scranton.
1894—Lawrence, F. Mortimer, M.D., 2840 Ridge Avenue, Phila.
1888—Layman, Alfred, M.D., 1630 N. 18th Street, Philadelphia.
1889—Lazear, Lyttleton Lyon, M.D., 515 Penn Ave., Pittsburg.
1887—Leake, E. N., M.D., Butler.
1884—Leckie, J. W., M.D., Hazleton.
1884—Lee, Charles H., M.D., New Castle.

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1891—Lee, W. H., M.D., New Castle.
1894—Lentz, Levi R., M.D., Fleetwood.
1894—Lichtenwalner, A. B., M.D., 2435 N. 7th St., Philadelphia.
1895—Lindabury, A. A., M.D., Scranton.
1892—Lukens, B. F., M.D., 25 W. Chelten Avenue, Germantown.
1896—Lyle, William Howard, M.D., 1833 Master St., Philadelphia.
1868—MACFARLAN, MALCOLM, M.D., 1805 Chestnut St., Phila.
1893—Macfarlan, Duncan, M.D., 3924 Chestnut St., Philadelphia.
1886—Maddux, D. P., M.D., Chester.
1878—Malin, William H., M.D., 8408 Germantown Avenue, Chestnut Hill, Philadelphia.
1892—Mansfield, Harry K., M.D., 19 W. Chelten Avenue, Germantown, Philadelphia.
1881—Mansfield, J. R., M.D., 4852 Germantown Ave., Philadelphia.
1891—Marks, William F., M.D., 118 N. 9th Street, Reading.
1885—Marsden, Biddle R., M.D., Chestnut Hill, Philadelphia.
1883—Marshall, Anna M., M.D., 1928 Chestnut St., Philadelphia.
1891—Marshall, R. S., M.D., Cor. Penn and N. Highland Avenues, Pittsburg.
1877—Martin, W. J., M.D., 1712 Carson Street, S. S., Pittsburg.
1878—Maurer, J. M., M.D., Washington.
1888—Mercer, Edward W., M.D., 157 N. 15th St., Philadelphia.
1871—Mercer, Robert P., M.D., 223 W. 3d Street, Chester.
1896—Merrell, A. F., M.D., Hallstead.
1888—Messervè, F. W., M.D., 1617 Arch Street, Philadelphia.
1871—MIDDLETON, CALEB S., M.D., 1523 Girard Ave., Phila.
1887—Millen, J. C., M.D., 1424 Poplar Street, Philadelphia.
1887—Miller, Z. T., M.D., 2013 Carson Street, S. S., Pittsburg.
1883—Mitchell, J. N., M.D., 113 S. 16th Street, Philadelphia.
1875—MOHR, CHARLES, M.D., 1823 Green Street, Philadelphia.
1893—Monroe, J. E., M.D., Orange, Mass.
1893—Moon, S. B., M.D., 1314 Eighth Ave., Beaver Falls.
1893—Moreland, George B., M.D., 1321 Fifth Avenue, Pittsburg.
1867—MORGAN, JOHN C., M.D., 1015 Arch Street, Philadelphia.
1891—Mueller, G. A., M.D., Allegheny.
1888—Murdock, Robert, M.D., 160 S. Main Street, Wilkesbarre.
1894—Myers, Charles Elwood, M.D., 170 Green Lane, Manayunk, Philadelphia.
1891—McCauley, J. C., M.D., 128 Connecticut Street, Rochester.
1879—McClelland, J. B., M.D., 409 Penn Avenue, Pittsburg.
1867—McCLELLAND, J. H., M.D., 5th and Wilkins Avenue, Pittsburg.

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1884—McClelland, R. W., M.D., 5th and Wilkins Avenue, Pittsburg.
1883—McClure, Eliza H. Lang, M.D., 1919 Wallace St., Philadelphia.
1893—McCracken, William, M.D., 2110 Carson Street, Pittsburg.
1891—Macdonald, T. L., M.D., 1106 New York Avenue, Washington, D. C.
1866—NEVILLE, W. H. H., M.D., 1833 Wallace St., Philadelphia.
1893—Northrop, H. L., M.D., 1729 Arch Street, Philadelphia.
1891—Norton, Claude R., M.D., 700 N. 40th St., Philadelphia.
1896—Palmer, Charles R., M.D., West Chester.
1884—Parker, G. W., M.D., 1404 S. 6th Street, Philadelphia.
1883—Parker, T. Elwood, M.D., Woodbury, N. J.
1870—PARSONS, ANSON, M.D., Springboro.
1881—Parsons, E. C., M.D., Meadville.
1880—Peach, William, M.D., 58 Monterey Street, Allegheny.
1881—Perkins, C. W., M.D., 403 Broad Street, Chester.
1894—Peters, J. Elwood, M.D., Jenkintown.
1883—Pettengill, Eliza F., M.D., 300 N. 10th St., Philadelphia.
1891—Phillips, Joseph R., M.D., 15 E. 8th Street, Erie.
1880—Pitcairn, Hugh, M.D., 206 State Street, Harrisburg.
1895—Pitcairn, R. C., M.D.
1894—Pollock, Martha H., M.D., 210 Pine Street, Harrisburg.
1891—Pond, Edward H., M.D., 515 Penn Avenue, Pittsburg.
1886—Posey, L. P., M.D., 1435 Walnut Street, Philadelphia.
1896—Powel, Franklin, M.D., Chester.
1883—Powell, W. C., Jr., M.D., Bryn Mawr.
1871—PRATT, TRIMBLE, M.D., Media.
1896—Pursell, James P., M.D., Easton.
1872—RANKIN, J. S., M.D., 827 S. Negley Avenue, Pittsburg.
1883—Reading, J. H., M.D., 1811 Green Street, Philadelphia.
1886—Reading, L. W., M.D., 1629 Green Street, Philadelphia.
1888—Reading, Thomas, M.D., Hatboro.
1896—Redman, John L., M.D., 1618 Pacific Ave., Atlantic City, N. J.
1886—Reeves, Joseph M., M.D., 1609 Mt. Vernon St., Philadelphia.
1896—Ridge, Jonathan T., M.D., 1617 N. 7th Street, Philadelphia.
1878—Rinehart, C. C., M.D., Center and Aiken Avenues, Pittsburg.
1894—Rinehart, S. M., M.D., 293 Western Avenue, Allegheny.
1891—Rittenhouse, J. S., M.D., 38 S. 4th Street, Reading.
1895—Roberts, C. W., M.D., Scranton.
1880—Robson, J. W., M.D., 350 Winebiddle Avenue, Pittsburg.
1887—Rodes, Joseph, M.D., San Diego, Cal.
1883—Rosseau, L. G., M.D., 118 S. Negley Avenue, Pittsburg.

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1892—Rossiter, E. B., M.D., 343 High Street, Pottstown.
1894—Rotzell, W. E., M.D., Narberth.
1888—Sandel, J. H., M.D., 49 Center Avenue, Plymouth.
1872—SARTAIN, HARRIET J., M.D., 212 W. Logan Square, Philadelphia.
1896—Schantz, Henry F., M.D., 30 National Bank B'ld'g, Reading.
1874—SCHMUCKER, F. R., M.D., 228 N. 5th Street, Reading.
1883—Schreiner, Emma T., M.D., 123 W. Chelten Avenue, Germantown, Philadelphia.
1889—Schwenk, C. S., M.D., 1319 Jefferson Street, Philadelphia.
1886—Seibert, W. A., M.D., 65 N. 4th Street, Easton.
1868—SEIP, C. P., M.D., 636 Penn Avenue, Pittsburg.
1889—Shallcross, I. G., M.D., 1631 Arch Street, Philadelphia.
1879—Shannon, S. F., M.D., 631 16th Street, Denver, Col.
1883—Sharkey, W. P., M.D., 1938 Girard Ave., Philadelphia.
1888—Sharpless, E. S., M.D., 1329 N. 12th Street, Philadelphia.
1885—Shellenberger, C. N., M.D., 1831 Wallace St., Philadelphia.
1895—Shepherd, Mary A., M.D., Scranton.
1892—Shoemaker, D. W., M.D., 1738 Green St., Philadelphia.
1883—Slough, F. J., M.D., 845 Hamilton Street, Allentown.
1883—Slough, W. C. J., M.D., Emaus.
1892—Smedley, Charles D., M.D., Wayne.
1880—Smedley, I. G., M.D., 1705 Arch Street, Philadelphia.
1889—Smith, George W., M.D., 806 N. Broad St., Philadelphia.
1887—Smith, Mary E., M.D., 48 E. Diamond Street, Allegheny.
1889—Smith, T. Hart, M.D., 1309 Girard Avenue, Philadelphia.
1887—Snader, E. R., M.D., 140 N. 20th Street, Philadelphia.
1894—Somerville, W. H., M.D., 1214 Hanover St., Philadelphia.
1896—Spahr, Charles E., M.D., York.
1889—Spencer, William, M.D., 1617 Chestnut Street, Philadelphia.
1881—Stambach, H. L., M.D., Santa Barbara, Cal.
1889—Starr, Pearl, M.D., Bellevue.
1894—Steele, William G., M.D., 1431 Girard Avenue, Philadelphia.
1891—Stephens, W. R., M.D., Wilkinsburg.
1896—Steudel, Robert, M.D., Phœnixville.
1894—Stewart, G. W., M.D., Oak Lane, Philadelphia.
1885—Strong, J. Wilmer, M.D., 2049 N. 13th St., Philadelphia.
1889—Strong, Walter, M.D., 2049 N. 13th St., Philadelphia.
1896—Surreth, Theodore, M.D., Scranton.
1889—Titman, George W., M.D., 5659 Germantown Ave., Phila.
1881—Thatcher, J. W., M.D., 35th and Hamilton Sts., Philadelphia.
1877—Thomas, Charles Monroe, M.D., 1623 Arch St., Philadelphia.

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1886—Tindall, Van R., M.D., 323 Reed Street, Philadelphia.
1886—Thompson, J. H., M.D., 515 Penn Avenue, Pittsburg.
1887—Thompson, Landreth W., M.D., 1701 Green Street, Phila.
1891—Tomlin, R. E., M.D., 2113 Franklin Street, Philadelphia.
1896—Tortat, Albin E., M.D., 3727 Ridge Avenue, Philadelphia.
1896—Trites, Charles S., M.D., 4500 Baker St., Manayunk, Phila.
1896—Ulrich, Silvester, M.D., Middletown.
1881—Umstead, D. B., M.D., Tacony, 23d Ward, Philadelphia.
1883—Van Baun, W. W., M.D., 1402 Spruce Street, Philadelphia.
1886—Van Deusen, Edwin H., M.D., 2101 Tioga St., Philadelphia.
1896—Van Lennep, G. A., M.D., 1421 Spruce Street, Philadelphia.
1881—Van Lennep, W. B., M.D., 1421 Spruce St., Philadelphia.
1889—Vischer, Carl V., M.D., 1429 Poplar Street, Philadelphia.
1892—Waggoner, G. W., M.D., Corry.
1896—Walter, Robert, M.D., Walter's Park.
1894—Ward, J. D., M.D., 806 S. 3d Street, Philadelphia.
1894—Ware, H. B., M.D., Scranton.
1881—Wareham, Edward A., M.D., Glen Rock.
1894—Wasserman, Flora E., M.D., 1909 N. Broad St., Philadelphia.
1894—Waylan, Julia Gould, M.D., 1832 Tioga St., Philadelphia.
1881—Weaver, Chandler, M.D., Fox Chase, 23d Ward, Phila.
1894—Weaver, H. S., M.D., 555 N. 16th Street, Philadelphia.
1883—Weaver, W. P., M.D., Bristol.
1894—Webster, Samuel C., M.D., Media.
1891—Wesner, M. A., M.D., Houtzdale.
1889—White, Roland T., M.D., 53 Jackson Street, Allegheny.
1892—Wilbur, B. K., M.D., Sitka, Alaska.
1866—WILLARD, L. H., M.D., 236 Western Ave., Allegheny.
1866—WILLIAMS, THOMAS C., M.D., 567 N. 5th St., Phila.
1873—WILLIAMSON, M. S., M.D., 1311 Arch St., Philadelphia.
1870—WILLETS, WILLIAM, M.D., Williamsport.
1886—Wilson, C. A., M.D., San Antonio, Texas.
1887—Wolfe, W. W., M.D., 35 N. Diamond Street, Allegheny.
1888—Yocum, C. A., M.D., 365 Chestnut Street, Pottstown.
1880—Yoder, D., M.D., Catasauqua.
1894—Ziegenfus, A. Frank, M.D., 1124 Wallace St., Philadelphia.
1896—Youngman, Maurice D., M.D., Atlantic City, N. J.

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HONORARY MEMBERS.

1883—Allen, H. C., M.D., 5401 Jefferson Street, Hyde Park, Chicago, Ill.
1866—Doran, Charles R., M.D., Jacksonville, Fla.
1868—Helmuth, William Tod, M.D., 158 W. 59th St., New York.
1885—Houghton, Henry C., M.D., 12 W. 39th St., New York.
1876—Jones, S. A., M.D., Ann Arbor, Mich.
1868—Paine, H. M., M.D., West Newton, Mass.
1883—Phillips, W. A., M.D., Cleveland, Ohio.
1868—Rockwith, F. A., M.D., East Saginaw, Mich.
1868—Talbot, I. T., M.D., 66 Marlborough St., Boston, Mass.
1892—Williamson, Alonzo P., M.D., Fergus Falls, Minn.

CORRESPONDING MEMBERS.

1873—Alvarez, Paz, M.D., Madrid, Spain.
1873—Chauvet, Fernand, M.D., Tours, France.
1873—Eidherr, Francis, M.D., Vienna, Austria.
1883—Hughes, Richard, M.D., Brighton, England.
1873—Pope, Alfred C., M.D., London, England.

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NECROLOGICAL LIST.

1866—Ashton, A. H., M.D., died February 18th, 1883.
1866—Barnaby, John E., M.D., died January 5th, 1869.
1867—Barrett, Charles B., M.D., died June 5th, 1871.
1882—Bernard, H., M.D., died ———
1866—Blakeley, W. James, M.D., died January 14th, 1877.
1870—Bratt, Benjamin R., M.D., died January 31st, 1872.
1866—Brooks, Silas S., M.D., died July 2d, 1871.
1883—Brown, Samuel, M.D., died March 22d, 1892.
1883—Burr, Richard, M.D., died March 30th, 1885.
1873—Caruthers, R. E., M.D., died January 3d, 1885.
1868—Charlton, S. T., M.D., died November 9th, 1886.
1863—Childs, William R., M.D., died November 11th, 1888.
1866—Cook, William H., M.D., died March 11th, 1879.
1866—Cote, M., M.D., died May 29th, 1878.
1866—Cowley, David, M.D., died October 30th, 1886.
1868—Dake, J. P., M.D. (honorary), died October 28, 1894.
1866—Detweiler, Henry, M.D., died April 21st, 1887.
1886—Dowling, John W., M.D. (honorary) died January 14th, 1892.
1871—Dreibelbis, David L., M.D., died March 24th, 1872.
1870—Earhart, Jacob R., M.D., died June 23d, 1891.
1870—Farrington, E. A., M.D., died December 17th, 1885.
1880—Ferson, John L., M.D., died July 12th, 1896.
1866—Freise, Michael, M.D., died February 4th, 1880.
1866—Frost, J. H. P., M.D., died January 21st, 1875.
1866—Gardiner, Richard, M.D., died March 22d, 1877.
1866—Gause, O. B., M.D., died January 11th, 1895.
1886—Griffith, Jethro J., M.D., died July 5th, 1893.
1877—Grumbeid, William, M.D., died———
1866—Guernsey, H. N., M.D., died June 27th, 1885.
1870—Guernsey, W. F., M.D., died February 16th, 1877.
1888—Hawley, S. B., M.D., died March 6th, 1890.
1886—Herron, James A., M.D., died November 15th, 1868.
1866—Hofmann, Herman H., M.D., died April 4th, 1891.
1884—Hosfeld, George, M.D., died November 9th, 1884.
1873—Houard, J. G., M.D., died April 24th, 1878.
1866—James, David, M.D., died June 6th, 1873.
1886—Jeanes, Jacob, M.D., died December 18th, 1877.
1866—Koch, Augustus W., M.D., died May 4th, 1886.
1866—Lee, J. K., M.D., died November 10th, 1887.
1869—Lee, John K., M.D., died May 31st, 1889.

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1876—Lilienthal, S., M.D. (honorary), died October 3d, 1891.
1867—Lippe, Adolph, M.D., died January 23d, 1888.
1871—Lovejoy, E., M.D. (honorary), died August 15th, 1872.
1868—Malin, George W., M.D., died January 18th, 1883.
1886—Malin, John, M.D., died November 29th, 1889.
1866—Marsden, J. H., M.D., died August 27th, 1883.
1865—Martin, Noah, M.D., died September 1st, 1889.
1881—May, Newton, M.D., died January 27th, 1889.
1866—McClatchey, R. J., M.D., died January 15th, 1883.
1870—Moore, Thomas, M.D., died March 25th, 1882.
1873—Nichol, Thomas, M.D. (corresponding), died June 14th, 1890.
1869—Ostrander, W. M., M.D., died August 23d, 1881.
1868—Payne, Wm. E., M.D. (honorary), died March 9th, 1877.
1878—Pereira, Ignacio, M.D. (corresponding), died April 18th, 1881.
1868—Pfoutz, J. S., M.D., died ———
1866—Preston, Coates, M.D., died August 9th, 1881.
1868—Pulte, J. H., M.D. (honorary), died February 24th, 1884.
1882—Pursel, J. E., M.D., died March 15th, 1885.
1866—Raue, Charles G., M.D., died August 21st, 1896.
1853—Reading, Edward, M.D., died March 7th, 1889.
1866—Reading, John R., M.D., died February 14th, 1866.
1870—Reinhold, H. E., M.D., died March 6th, 1879.
1871—Rittenhouse, S. R., M.D., died June 26, 1895.
1866—Roberts, R. Ross, M.D., died April 4th, 1875.
1866—Rosseau, L. M., M.D., died September 25th, 1882.
1872—Scott, James L., M.D., died August 15th, 1876.
1883—Skeels, James S., M.D., died ——— 1891.
1870—Spencer, J. H., M.D., died ———
1872—Speth, W. F., M.D., died May 11th, 1881.
———Stauffer, D. R., M.D., died March 16th, 1874.
1867—Stevens, C. A., M.D., died January 17th, 1881.
1870—Taudte, F., M.D., died March 27th, 1878.
1871—Thomas, Amos R., M.D., died October 31st, 1895.
1891—Tindall, Harry Brooks, M.D., died January 9th, 1892.
1882—Trites, W. B., M.D., died January 19th, 1890.
1867—Walker, Mahlon M., M.D., died March 31st, 1896.
1870—Waters, George H., M.D., died ——— 1892.
1880—Way, J. H., M.D., died September 3d, 1887.
1866—Williamson, Walter M., M.D., died December 19th, 1870.
1866—Williamson, Walter, M.D., died May 5th, 1874.
1848—Wood, James B., M.D., died April 14th, 1889.
1874—Young, J. H., M.D., died June 21, 1894.
1880—Zerns, Wm. M., M.D., died September 21st, 1887.

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MEMBERS AND VISITORS REGISTERED AT THE MEETING.

F. L. Abbott.
R. C. Allen.
L. T. Ashcraft.
C. A. Ayers.
George F. Baier.
A. W. Baily.
A. M. Barnes.
C. Bartlett.
W. D. Bayley.
Chas. Becker.
W. H. Bigler.
J. P. Birch.
Mary Branson.
Mary Brewer.
F. W. Brierly.
C. S. Brown.
W. K. Brown.
W. H. H. Bull.
F. W. Burlingame.
J. M. Caley.
W. D. Carter.
J. L. Cheesman.
G. M. Christine.
Anna C. Clarke.
J. H. Closson.
Mary Cochran.
Mary A. Cooke.
E. G. Cowperthwait.
Isaac Crowther.
J. B. G. Custis.
R. G. Dock.
Pemberton Dudley.
Anna E. Dumont.
T. S. Dunning.
P. H. Ealer.
L. K. Esrey.
J. F. Fischer.
J. R. Fleming.
C. J. V. Fries.
H. S. Furman.
W. H. Gardiner.
C. B. Gilbert.
I. B. Gilbert.
S. G. Godshall.
E. M. Gramm.
G. E. Gramm.
T. J. Gramm.
H. G. Griffith.
L. B. Griffith.
W. M. Griffith.
J. C. Guernsey.
B. B. Gumpert.
O. S. Haines.
R. J. Harris.
R. T. Hart.
J. W. Hassler.
M. Margaret Hassler.
J. M. Heimbach.
W. T. Helmuth, Jr.
W. T. Helmuth, Sr.
A. C. Heritage.
W. M. Hillegas.
W. H. Hinds.
M. J. Holben.
J. Hollowell.
E. M. Howard.
T. C. Imes.
B. W. James.
J. E. James.
G. C. Jenkins.
Mary B. Jepson.
H. I. Jessup.
J. E. Jones.
E. H. Kase.
B. F. Kehler.
W. H. Keim.
W. R. King.
D. C. Kline.
Augustus Korndœrfer, Sr.
E. A. Krusen.
H. A. Lacy.
N. F. Lane.

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F. M. Lawrence.
J. P. Lukens.
W. H. Lyle.
Eliza L. McClure.
C. Elizabeth McGovern.
F. P. McKinstry.
D. P. Maddux.
W. W. Maires.
Anna M. Marshall.
W. J. Martin.
E. W. Mercer.
F. W. Messerve.
C. S. Middleton.
M. F. Middleton.
Z. T. Miller.
M. L. Munson.
C. E. Myers.
H. L. Northrop.
A. B. Norton.
C. R. Norton.
C. R. Palmer.
T. E. Parker.
E. H. Paxson.
R. R. Paxson.
C. W. Perkins.
J. K. M. Perrine.
E. H. Phillips.
J. D. Pines.
Hugh Pitcairn.
Chas. Platt.
E. H. Porter.
Trimble Pratt.
C. S. Raue.
C. L. Reading.
J. H. Reading.
L. W. Reading.
J. L. Redman.
G. W. Roberts.
H. D. Rosenberger.
Antoinette E. C. Russell.
J. H. Sandel.
H. F. Schantz.
F. R. Schmucker.
Emma T. Schreiner.
C. S. Schwenk.
I. G. Shallcross.
J. G. Sharp.
E. S. Sharpless.
D. W. Shoemaker.
W. L. Shoemaker.
C. W. Simmons.
I. G. Smedley.
Anna A. Smith.
G. W. Smith.
L. A. Smith.
E. R. Snader.
W. Spencer.
W. G. Steele.
Lydia W. Stokes.
W. Strong.
E. C. Thomas.
L. W. Thompson.
Van R. Tindall.
R. E. Tomlin.
W. H. Tomlinson.
Ella M. Tuttle.
W. W. Van Baun.
F. Van Gunten.
G. A. Van Lennep.
W. B. Van Lennep.
C. V. Vischer.
Robert Walter.
J. M'E. Ward.
Julia G. Waylan.
Chandler Weaver.
L. W. Webb.
F. H. Widman.
F. E. Williams.
E. H. Wolcott.
G. H. Woodward.
F. E. Yerkes.
C. A. Yocom.
M. D. Youngman.
A. F. Ziegenfus.

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Proceedings of the Session of Wednesday Evening, September 30, devoted to the Exercises in Commemoration of the Centennial of the Promulgation of Homœopathy by Hahnemann,

INCLUDING

The President's Annual Address.

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PRESIDENT'S ANNUAL ADDRESS.

Ladies and Gentlemen, Members of the Homœopathic Medical Society of the State of Pennsylvania:

The Scientific Claim of Homœopathy.

The centenary epoch of a reformation improving the condition of mankind stamps the original event as one of the great factors governing the health and social status of the civilized world.

The year 1896 brings with it the *Centennial of Homœopathy*, and it is our privilege to come together to-night and celebrate in fitting manner the hundredth anniversary of the reformation of medicine—the lifting of therapeutics from the quagmire of absurdities to the solid rock of a science.

A century ago, Hahnemann, after studying and observing the practice of medicine by the most able practitioners of the day, and after thoroughly familiarizing himself with the ancient and modern literature of medicine, found himself, against his inclination, forced to the position that the therapeutics of his day were founded only upon "vague observations" or "fanciful conjectures," and that their curative factor was practically *nil.*

Having the courage of his convictions, he scorned and ridiculed the absurdities and false pretensions of the medical profession and abandoned a lucrative practice; and, becoming a literary hack to keep his family from starvation, he continued, under great trials and tribulations and much care and sorrow, his search for an ideal healing, which, to his mind, in contrast to the complicated and loathsome nostrums of his time, was a speedy, gentle and permanent restoration of health in the shortest, safest and most reliable manner, according to clearly intelligible reasons.

Working along the line of what a physician should really know, it became clear to Hahnemann that a knowledge of two series of phenomena were essential. First, it was absolutely

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necessary to know what was really curable in disease, and secondly and of equal importance was a knowledge of what was curative in drugs; or, more literally, the therapeutist must be familiar with the phenomena presented by the patient, and with the phenomena drugs are capable of producing upon the human system.

With this knowledge at command there were, then, two series of phenomena, each independent of the other, and each capable of infinite progress in each of its elements without endangering it as a whole.

Hahnemann knew that "the true healing art is in its nature a pure science of experience, and can and must rest on clear facts and on the sensible phenomena pertaining to their sphere of action, for all the subjects it has to deal with are clearly and satisfactorily cognizable by the senses through experience."

With patient, painstaking care the two sets of phenomena were brought to a high state of development and a commendable knowledge of disease to be treated, and a knowledge of the effects of medicine on the healthy human organism was secured. But this was not sufficient. Each set of phenomena was in right line for future development and perpetuation, but there was absolutely no existing connection between the two; there was still something needed to enable the successful application in the curing of the sick of the knowledge thus gained in pure experimental research. The third element required to place therapeutics upon a scientific basis and bring it in harmony with the other natural sciences dependent upon the inductive method was a general formula or natural law guiding to, or expressing, the constant relation between the two known series of phenomena, which was to serve as the therapeutic law and to furnish the clear, distinct reason for selecting the remedy necessary for the removal of the diseased condition.

Again the genius of Hahnemann was equal to the task, the magnitude of which can be better appreciated and partially realized when it is recalled that for 2500 years millions of physicians, many of them earnest, sincere men, had worse than failed to reach the desired goal—a scientific basis for therapeutics. The boasted accumulated experience of 2500 years had

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been stupidly and wastefully barren of practical results until Hahnemann masterfully brought order out of chaos by seizing upon and utilizing the principle or law recognized ages before and put to trifling use by Hippocrates, and which is so aptly expressed, *Similia similibus curantur.*

The inductive tripod was now completed, and therapeutics at last, like all other natural sciences, had supporting it a scientific base. And, as Dunham cleverly describes it, the elements of the therapeutist's science are now the facts that "he has to deal with a subject known by its phenomena—the sick body; with an agent known also by its phenomena—the drug; and with a law which shall tell how to apply the agent to the subject for the accomplishment of a cure—a law which shall express the general relation between the drug and the morbid organism;" the problem being, "Given the therapeutic law, and a curative series of phenomena of natural or drug disease, to find the corresponding series of phenomena of drug or natural disease."

Theoretically this is seemingly simple, but the practical application of the law is met by a multiplicity of difficulties. Each series of phenomena calls into play every department of medicine and its collateral sciences, anatomy, physiology, chemistry, pathology, physics, psychology, etc., and the difficulties at times are seemingly well-nigh insurmountable, as we have all experienced.

Hahnemann in homœopathy discovered, outlined and employed the science of therapeutics, for in his work he arranged medical knowledge in accordance with natural law, and in the past century his followers have not been, nor will they ever be, able to add to or take away from its essential requirements; and its central law, within its limitations, is as fixed and unchangeable as the law of gravitation.

The century has not gone for naught, however, for the profession has acquired a more correct understanding and appreciation of the two great series of phenomena, and has made extensive additions to each series, and has infinitely enlarged the scope of each.

As told by Hahnemann, we have learned from practical experience that the more general and close the similarity between

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the phenomena of the drug-symptom series and the phenomena of the disease-symptom series, the more certain it is that a curative effect will be obtained, and we are thus furnished with the strongest possible evidence of the validity of the scientific position of homœopathic therapeutics.

The homœopathy of Hahnemann is absolutely dependent upon philosophical induction, as are all natural sciences. Now, as is well known, each natural science has as an attribute the power of foreshadowing or foretelling future events within its own special domain. How is it with homœopathy in this test of prevision? Will it come up to the full measurement of requirements, as do other natural sciences? The law of relation —*similia similibus curantur*—given, and one series of phenomena, can it predict from the other series of phenomena, when known, what has not been observed, and prove it by results? How completely homœopathy fulfills this demand of natural science is not only gratifying to the profession, but it has also proved to be an inestimable boon to humanity in the past, as it will surely continue to be in the future, to countless generations. Before I recall the oft-told tale, your minds are full of Hahnemann's triumphant demonstration of the validity of homœopathy's claim to the science of therapeutics in that terribly fatal invasion of Asiatic cholera which swept Europe in 1831.

In extenuation of the terrible mortality accompanying this epidemic the old-school physicians explained that the disease was new to them; that they had never met with it before, and, consequently, they had not had an opportunity to study its effects and ascertain the means necessary for its cure. So cholera numbered its victims by the thousands, the tens of thousands, and the hundreds of thousands, while humanity waited in horror and despair for the wiseacres of the ancient craft of medicine to add still further contributions of "vague observations" to the emptiness and worthlessness of their therapeutical system. The shallowness of their pretense was vividly shown when, after exceptional opportunities for critical experimental research, they had an equally enormous fatality in the subsequent epidemics following rapidly upon the first invasion.

Not so with homœopathy! Hahnemann was master of the

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law of scientific therapeutical relation. He was master of the series of phenomena of drug-proving, and when given the series of phenomena-production of Asiatic cholera, the prevision of natural science, in the special domain of therapeutics, enabled him to point unerringly to the curative measures, and he dogmatically stated what remedies were curative for each stage of the disease before having seen a single case of cholera Asiatica. He had his directions for treatment printed and sent to his disciples, physicians and laymen, by the thousands, arming them for prophylaxis and treatment long before the actual invasion of the epidemic; and the results obtained, even those of the medically untrained laymen, in comparison with those of the most skilled of the allopathic profession, were of startling superiority. This splendid success of prevision of Hahnemann's system placed homœopathy on the level with the other natural sciences. We cannot do more, but our share of duty is to enrich each series of phenomena and to reach a wider application of the law governing their general relation.

I have been dwelling solely upon the scientific side of homœopathy without reference to the collateral issues which are seemingly as essential; first, because another will address you this evening on "THE HOMŒOPATHY OF HAHNEMANN," and, secondly, for the reason that in our attitude towards those of our profession who still hold themselves aloof from the truth, and who are not interested in facts tending to prove their error, we should concentrate our best thought and efforts upon this one great central truth of homœopathy—*similia similibus curantur*—the law governing the relation between what is curable in disease and what is curative in drugs. With this truth driven home to full acceptance by our opponents, all else vital to its interests and development will be merely a question of time as to full acceptance.

Hahnemann's wonderful analytical and synthetical mind, with its keen penetration and its mighty ability to take and apply the truth of knowledge with logical perfection, led him to the scientific basis of therapeutics. This is our heritage. He has left us a priceless treasure in his work of its application, may we utilize it to the full extent of our ability, and

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carry its truth into the camp of the therapeutical nihilist, the self-styled "rational" school of medicine.

The test of one's homœopathy should be the recognition of its scientific status, and its application to the best of his ability. This contains all things necessary, and should be the ultimate standard of one's fitness.

The acceptance of the scientific basis carries an associate acknowledgment that its application is limited strictly to its own domain. What these limitations are and the percentage of cases in actual practice coming within its scope has recently been fully dwelt upon by one of our strongest writers, Dr. Dudley, in an article of exceptional merit upon the "Scope and Limitations of the Law of Cure," in which he also presents and justifies with great force the distinctiveness and limitations of the position taken and maintained by homœopathy. In summing up he says: "If the totality of symptoms has, as its present and maintaining cause, a disorded vital activity, such a totality may be expected to yield to the homœopathic drug; and this result will probably ensue in all cases in which the organism still retains sufficient reactive energy. It is in this particular that the law of cure is probably universal in its application and operation.

"Even if, between the functional cause and its resulting symptom-group, there should have arisen some structural lesion involving a change in the physical or chemical relations and conditions of the parts; that is, if the structural lesion has resulted from the vital disorder, and the symptoms, or some of them, have sprung from the mechanical or physical effects of the structural change, in such a case it seems not illogical to expect the homœopathic remedy to remove the entire complex of conditions, functional cause, structural lesion, symptoms and all; though the selection of the remedy would be much more difficult than in cases less complicated. . . . In these two classes of cases, it would seem, we shall find the scope of the operation of the homœopathic law. It is a very wide and comprehensive domain, and includes, probably, more than 90 per cent. of the cases that come under the care of the ordinary practitioner."

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A skilled follower of Hahnemann will have but little difficulty in reaching the 90 per cent., but men's ability varies, and the significance of facts depends entirely upon the scope of a man's ability of recognition. Many will readily see and pick the truth of relationship existing between the phenomena of disease-symptoms and the phenomena of drug-symptoms, and apply successfully the law governing the relation existing between these two series of phenomena, in fully 90 per cent. of their cases, while others may only be able to apply it to 60 per cent. of their cases, and yet be truthfully practicing homœopathy to the full limit of their ability.

* * * * * *

The treatment of the cases which do not come within the domain of the homœopathic law has given rise to much misunderstanding in our own ranks and to many bitter attacks from our opponents, who either do not understand our position or else who wilfully pretend that homœopathic physicians have no right to use methods which are not strictly within the keeping of the law. As physicians we are interested in the cure of our patients, and yet 10 per cent. of our curable patients are not within the scope and application of the law.

A cure has been defined as a "change from disease to health caused and determined by artificial means." Homœopathy refers directly to drug therapeutics, while therapeutics in general comprehends the science of curing disease. There are a certain number of cases in which drugs may not be called for at all, so a physician must be even more than a therapeutist; consequently there is nothing restricting the homœopathic physician from using any helpful measures in the treatment of cases which do not come within the scope and limitations of the homœopathic law.

It would be interesting to develop this subject and to branch out into other lines, but there is a time-limit, and a presidential address by an unwritten law must partake in part of the business properly coming before the Society.

To Do Away With the Reading of Papers.

The functions of a State medical society are of two kinds,

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the scientific and the executive; under the former it will be well for us to consider if we are working on the broadest and most efficient plan, and if we are deriving by our present methods the greatest possible good for the largest number.

Our Secretary has presented us with a programme of unexceptional merit announcing the titles of seventy-nine articles by able writers, and there have been received, in addition, six unannounced papers, making eighty-five in all. Three of the papers are arranged for Tuesday evening, September 29, 1896, thus leaving eighty-two to be read in the sixteen hours provided for in the programme, part of which time must necessarily be devoted to the business of the Society. The by-laws provide that no paper shall occupy more than fifteen minutes in reading. While a few papers will be presented in less than the allotted time, the tendency will be to overreach the limit, and the average will be fully up to the standard. Eighty-two papers of fifteen minutes each will consume twenty-one hours, or six more than the programme provides, allowing no time for the business of the first day of the session. Of course we can utilize some of the time of the third day of the meeting, but there would still be no time for discussion—for that interchange of thought and experience which is really the vital principle of the scientific sessions.

I do not desire to dampen the enthusiastic and admirable efforts of our members, which are certainly commendable and deserving of praise, and which are unequaled by any similar association, and yet I do wish to suggest the wisdom of changing our policy from one of many carefully-prepared written papers, with little or no discussion, to one of a few papers similarly prepared, with an earnest, thoughtful discussion, by many members of the Society, on each subject presented, thus magnifying the debate, and eliciting, in the interchange of thought, important information that would otherwise be overlooked.

At the first meeting of the International Congress of Homœopathic Physicians held in Philadelphia in 1876, the essays and papers presented to the Congress were printed in full beforehand and were distributed to the members who desired copies to familiarize themselves with their contents in order to prepare

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for careful discussion. The same plan, improved, was followed with still greater success at the recent International meeting held in London in August of this year; and, in view of the admirable results there attained, I would suggest that each bureau chairman be directed to have his bureau carefully prepare two or three papers on the same or different subjects, the MSS. of which shall be placed in the hands of the Corresponding Secretary sixty days before the time of next meeting, and that he shall be instructed to have the same set up in type and a sufficient number of copies struck off to supply those who may need them. Further, that these papers shall not be read at the sessions, excepting in brief abstract, which shall be made by the author of the article or by the bureau chairman; that one or two members of the bureau shall be appointed to open the debate on each paper, there being a ten minutes' time-limit to all discussions. The subject then to be thrown open to general debate by any member of the Society, it being distinctly understood that no debating shall be done from manuscript.

Members wishing to participate in the debates can readily secure copies of the papers needed from the Secretary beforehand, and prepare themselves to handle the subject with intelligence, understanding, and to the point.

With this plan inaugurated and carefully carried out our debates will assume a practical value to every member of the Society that they have not attained by past and present methods.

The extra financial cost to the Society will be trifling, as the Secretary will simply print the papers before the meeting instead of afterwards, and the charge will be for extra copies—about fifty each.

Incorporation.

The first session of the Homœopathic Medical Society of the State of Pennsylvania was held in Pittsburg, June 5, 1866, and thirty-odd years have since passed by, and our Society has not yet sought to receive legal recognition by incorporation under the laws of the State of Pennsylvania. The act of incorporation gives an air of permanency and solidity to an institution that cannot be otherwise secured. It shows to the world that

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there is a union of interests between the organization and the State; that the members of the Association are responsible, and that they have faith and reliance in themselves; and, further, that they have no hesitancy to place themselves under the laws of the Commonwealth. Again, the American Institute of Homœopathy has organized a movement by means of an Interstate Committee to bring all of our State societies into a harmonious whole, acting together to a common end. It is desirable that all of these societies be incorporated and receive the recognition of the law, and it is disquieting to find the veteran Pennsylvania society still lagging in this respect. The Pennsylvania State Society has always rendered active aid and hearty support to the American Institute; and for our own interests, as well as to aid and sustain by our example this excellent work of the Institute, I would urgently suggest that you direct your officers to take immediate steps to secure an act of incorporation for the Homœopathic Medical Society of the State of Pennsylvania.

Insane Asylum.

The time has arrived for renewed and increased effort on our part to have the State of Pennsylvania make proper provision for the care of the insane for whom homœopathic treatment is desired.

Representing, as we do, the medical preference of a large class of taxpayers, we have the right to make such a demand, and when we can back the request by results in treatment of the insane in asylums far surpassing those of the allopathic school, our duty compels us to urge insistently our claim for recognition. The members of the Legislature will make no effort to correct this evil unless their attention is personally directed to the situation by those directly interested, and it now becomes the duty of each member of the State Society, and of every homœopathic physician in the State, to make an individual and united systematic appeal to the members of the Legislature for the establishment of an insane asylum, to be under the sole medical care of physicians of the homœopathic school.

The State should not shower an abundance of care and pro-

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vision upon one class of her citizens, as she has done at Norristown, Harrisburg, Danville, Warren, Dixmont and Wernersville, and at the same time neglect and ignore her duty to those of another class who are now compelled to contribute nearly a third of the taxes supporting these institutions without representation, thus denying the physicians of our school our rights, and our patients the privilege of the treatment of their selection. The members of the Legislature are honest, fair-minded men, and, as a rule, are free from medical prejudice. They willingly recognize the claims of all classes of citizens, and when they comprehend that previous legislation has created and established in power a State medicine, they will correct the evil and extend equal protection and exact justice to all and special privileges to none. We have no desire nor intention to interfere with the rights of allopathic physicians, but we intend calling a halt upon their monopoly of the State medical appointments, and ask for an equitable distribution of public patronage by the establishment of a well-equipped State hospital for the insane, to be devoted to the use of those desiring homœopathic treatment.

During the Session of 1895 the Legislature, in both House and Senate, passed, by a nearly unanimous vote, a bill making ample provision for the beginning of an insane hospital under homœopathic treatment, and the Governor, by the exercise of his veto-power, deprived nearly two millions of people of the State of a privilege they had been justly seeking for years.

I would suggest that the attention of the Legislative Committee be especially called to this important matter, and that they be requested to again lay before the Board of Charities a request for a homœopathic State hospital for the insane, and that we assure the committee of our individual and united support and hearty co-operation in whatever steps they may find necessary to take for the purpose of obtaining the grant of such an institution.

Medical Expert Testimony.

I desire to invite your attention and consideration to the present status of medical expert testimony as found at our

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courts, the standard of which has been gradually sinking through incompetent experts until it has reached an unenviable level, and reflects discreditably upon the medical profession. It is desirable that a change be made in our present system, whereby the physician to give expert testimony for the defendant or plaintiff be named by the courts and not by the attorney for either side, such experts being selected by the courts as are recognized to be proficient in special lines by the medical fraternity, the selection being made from lists of experts furnished the courts by the societies representing the different medical schools in the State. With such a method in vogue the courts would have no difficulty in picking out competent experts, and, as court officers, they would receive the protection that is now in many cases denied them, and the disgrace and injustice arising from incompetent physicians giving expert testimony would be done away with, and the results attained would be decidedly better than in many instances at present. I would suggest the appointment of a committee of five, or more, to carefully review during the coming year the question of medical expert testimony, and to report at the next annual meeting of this Society.

Before concluding, permit me to extend to our distinguished visiting guests, William Tod Helmuth, M.D., Dean of the N. Y. Homœopathic Medical College; Dr. J. B. Gregg Custis, Washington, D. C., President of the American Institute of Homœopathy; Dr. Edwin H. Wolcott, Rochester, President of the Homœopathic Medical Society of the State of New York; Dr. M. F. Middleton, Camden, President of the New Jersey State Homœopathic Medical Society; Dr. J. Paul Lukins, Wilmington, President of the Delaware Homœopathic Medical Society; Dr. A. B. Norton, New York City, President of the National Ophthalmological, Otological and Laryngological Society and of the National Electro-Therapeutical Society; Dr. Eugene H. Porter, New York City, Secretary of the American Institute of Homœopathy and Editor of the *North American Journal of Homœopathy;* Dr. Wm. R. King, Washington, D. C., Secretary of the National Ophthalmological Society; Dr. George W. Roberts, New York City, Surgeon to the Hahnemann Hospital, New York;

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Dr. Peter Cooper, Wilmington, President of the Delaware State Board of Medical Examiners; William Tod Helmuth, Jr., M.D., New York, Surgeon to the Flower Hospital, New York City; Chas. B. Gilbert, M.D., Washington, Delegate from the Washington, D. C., Homœopathic Medical Society; Drs. E. H. Phillips of Cape May, E. M. Howard and George D. Woodward, Camden, N. J.; Drs. M. D. Youngman, A. W. Baily, John R. Fleming, M. L. Munson, of Atlantic City, N. J.; T. Elwood Parker, Woodbury, N. J.; John L. Cheesman, Elmer, N. J.; F. P. McKinstry, Washington, N. J., and others, many of whom have come long distances to be with us, a hearty, whole-souled welcome, and to express to them our deep sense of gratification of the honor of their presence, and we trust their visit may be so pleasant and profitable that they will be as unwilling to leave us as we are to part with them.

Ladies and gentlemen, in conclusion, I thank you for the honor you have conferred upon me in calling me to assume the responsible duties of presiding officer. With your co-operation we will endeavor to expedite our business and scientific work, and I hope the mutual benefit derived will enable us to return to our homes with that sense of satisfaction springing from time well spent.

SAMUEL HAHNEMANN, THE MEDICAL REFORMER OF THE EIGHTEENTH CENTURY.

BY JOSEPH C. GUERNSEY, A.M., M.D., PHILADELPHIA.

To say all that my theme demands would equal the task of a laborer commanded to drain a shoreless and bottomless ocean, or the work of a miner directed to bring out all the gold of an inexhaustible mine. Let me, then, beg only your brief attention while I present a few facts indicating Hahnemann's advanced stand and progressive tendency, which will enable us to realize in some degree, at least, his value as a true leader in medical reform.

I. He was probably the first doctor in the world to introduce

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the mild, humane, non-restraint method in the treatment of the insane. He did this while in charge of the asylum in Georgenthal in 1782. He would not allow any insane person to be punished by blows or other painful corporeal infliction, "for," said he, "there can be no punishment where there is no responsibility; such parties cannot be improved, but must be rendered worse by rough treatment."

II. He was a pioneer in hygiene. In his first original medical work, a treatise on scrofulous sores, published at Leipsic in 1784, at a time when almost nothing was known of hygiene, he showed a fair knowledge and appreciation of its value by recommending exercise and open air; he scored a brilliant and most enviable achievement by pointing out the benefits of a change of climate and the sea-shore; by emphasizing the use of cold water as a remedial agent, and the necessity of cleanliness.

III. In the same work (referred to in § II.) he foreshadows the successful antisepsis of the present day; for, in speaking of the treatment of a caries of one of the metatarsal bones, he said: "I scraped the carious bone clear out, and dressed it with alcohol." A little later, 1788, in an *Essay on a New Agent in the Prevention of Putrefaction*, he taught that nitrate of silver is an antiseptic in a solution of 1-1000, and he observed antiseptic effects from a solution of 1-100,000.

IV. As a chemist, Hahnemann was so rarely skilled that no one of his time surpassed him. But in 1789 he eclipsed himself and all his rivals by publishing his discovery of the "exact mode of preparing the soluble mercury," a secret which had long and earnestly been sought by chemists with almost as much avidity as was the philosopher's stone in olden times.

V. In 1831 he announced the germ theory, which stands today an accepted fact as a cause of disease all over the world. In an "Appeal to Thinking Philanthropists Respecting the Mode of Propagation of the Asiatic Cholera,"* he used these memorable words: "The cholera miasm finds a favorable element for its multiplication, and grows into an enormously increased brood of those excessively minute, invisible, living

* See Hahnemann's *Lesser Writings*.

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creatures (*in other words, germs*), so inimical to human life, of which the contagious matter of the cholera most probably consists . . . . the invisible cloud . . . . which is composed of, probably, millions of these miasmatic animated beings." He closed his remarkable essay with these prophetic words: "Dixi et salvavi animam;" and, truly, life is saved when these germs are destroyed, or, better still, are kept from our shores by a strict quarantine.

But these exploits, striking and noteworthy as they are, are only incidental. That which marks Hahnemann pre-eminently and peculiarly as the medical reformer of the eighteenth century demands fuller treatment.

VI. In the year 1781, being deeply in love with an apothecary's daughter, he sought and obtained the appointment of parish doctor at Gommern, a small town near Magdeburg. On the salary of this office, to use his own words, "I began to experience domestic happiness," and in about a year his first child was born.

While at Gommern he began to suspect that the principles of medical science had always been uncertain and imperfect, and soon he became convinced that none of the diverse and contradictory methods of cure at that time employed could be really beneficial to the sick. He believed that a new and better system was needed, and the discovery of this new and better system became his life's work. To his imperishable honor and glory be it remembered that until he could find the true principles of medical science he deemed it impossible, because irreconcilable with his conscience, to practice medicine at all. Yea, for conscience' sake, he reduced himself and family to *absolute want!*

But regardless of pecuniary loss he devoted himself to chemistry, and through this study, in the year 1790, his genius caught the first idea of the system which he afterwards founded. How he undertook the translation of Cullen's *Materia Medica*, and from that work was led to his experiments with Peruvian bark and his deductions therefrom need not be repeated here, for those labors and their results, pregnant with so much good to the human race, now and forever, are "as familiar household words" to us all.

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It was from these studies and experiments that there came forth, as a beacon of light from the dark abyss of ignorance, superstition and error, the formula, "*Similia similibus curantur*," a free interpretation of which is, "Diseases are to be cured by those medicines which produce symptoms most nearly resembling them in the healthy body."

VII. Hahnemann's most exploited work as a reformer consisted in his discovery of Nature's own law of cure, "Similia similibus curantur;" but it is of equal, if not greater importance, that he taught how we may exactly *learn the effects of drugs, i.e.*, BY PROVING THEM upon the human system. The vast importance of this discovery has been too little realized and recognized by the medical profession. Before Hahnemann's day, and in his day, there was nothing in the domain of medicine about which there was less knowledge or more uncertainty. It is impossible for us of the present day to conceive of the dense darkness which shrouded the medical profession on this all-important point. Hahnemann has been justly lauded to the skies for his grand discovery of the *law of cure*, but hardly ever do we hear the meed of praise awarded him for his not the less important discovery of how to learn the materia medica—that is, how to learn the effects of drugs upon the human system. I say not the less important, because *upon* the knowledge of the effects of drugs on the human economy rests the law of how to use drugs, viz., "Similia similibus curantur."

Consider the state of things in Hahnemann's day. Rusch, who wrote, "Failure in a cure is occasioned by ignorance either of the disease or of the medicine. We have *not only* increased the number of diseases, but have rendered them more fatal." Schultz wrote from Heidelberg, "The mischief perpetrated by physicians employing medicines the effects of which are perfectly unknown to them in diseases, in symptoms they rarely know, of whose nature they are totally ignorant, is most alarming." Says Jorg, in the preface to his *Materia Medica*, "It is a matter for regret that we know very little of the true *effects* of medicines and *their influence* on the *human body*. Every competent judge fully understands that such a defect in our information *renders our practical exertions nearly useless*." In comparatively recent days, and in our own country,

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Dr. Benjamin Rush, disgusted at the ignorant and injurious manner in which medicines were administered to the sick, cried out, in the agony of his soul:

> "If all drugs were sunk in the bottom of the sea,
> It would the worse for fishes and the better for mankind be!"

And now listen to Hahnemann's own plaint: "It was agony for me to walk in darkness . . . . and to prescribe according to such and such an hypothesis concerning diseases, substances which owed their place in the materia medica to an arbitrary decision. I could not conscientiously treat the unknown morbid conditions of my suffering brethren with these unknown medicines, which, being very active substances, may (unless applied with the most rigorous exactness, which the physician cannot exercise, because their peculiar effects have not yet been examined) so easily occasion death, or produce new affections and chronic maladies, often more difficult to remove than the original disease. To become thus the murderer or the tormentor of my brethren was to me an idea so frightful and overwhelming that, soon after my marriage, I *renounced* the practice of medicine, that I might no longer incur the risk of doing injury."

VIII. But still more renown is due our Hahnemann. To him belongs all honor for discovering how to administer the materia medica, namely, in the smallest dose that will cure. To this reform the very allopaths have yielded, and everywhere in their preaching and practice to-day we find them, too, teaching and administering the small dose. This one triumph alone was worth living for.

These three points, then—*a.* The discovery of how to learn the effects of drugs upon the human system; *b.* The law of the application of drugs to cure sickness; *c.* The administration of drugs in the proper form, *i.e.*, in the smallest dose—make up the trinity of Hahnemann, the medical reformer of the eighteenth century.

But let us for a moment refer again to what was undoubtedly the greatest of all Hahnemann's reforms, and the one of greatest interest to the homœopathic profession—which was to teach

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the true and only way of discovering the effects of drugs upon the human system, and the proper way of giving drugs—viz., the smallest dose that will cure. Consider the value of the proper study, united with the correct prescribing, of the materia medica. It is the foundation-stone of homœopathy and of all true medicine, the foundation upon which stands the art of healing the sick. The materia medica, which of old was the stone rejected of all the medical builders as unfit for use, was hewn, trimmed and dressed by Samuel Hahnemann, so that it has become the corner-stone of therapeutics. Yea! it is the keystone to the arch of the practice of medicine, which supports its whole weight.

"Non inutilis vixi" were Hahnemann's last words; and he spoke not vainglorioously. His life had been not only that of the medical reformer of the eighteenth century, but he was the greatest medical reformer of all centuries.

We may say of him as King David did of Solomon, "His name shall endure for ever: his name shall be continued as long as the sun: and men shall be blessed in him: all nations shall called him blessed."—Psalm lxxii., 17.

THE HOMŒOPATHY OF HAHNEMANN.

BY AUGUSTUS KORNDŒRFER, SR., M.D., PHILADELPHIA, PA.

This year, 1896, marks the boundary between the first and the second century in the development of the most beneficent system of medicine ever revealed unto men, *Homœopathy*.

Disease in all its hideous forms and with all its distressing terrors, its days of pain and its nights of torture, despite the most earnest efforts of the physicians of the past, held cruel sway over its suffering victims. The frenzied patient still pleaded in vain for a single draught of cold water wherewith to slake his burning thirst. The hopeless, helpless invalid still sought far and wide some fancied panacea wherewith to strengthen the tottering limbs or reinvigorate an equally decrepit mind. Yet nowhere could help be found.

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Confusion of theories worse confounded in incongruous and harmful methods of practice baffled the honest though illogical and unphilosophic physician of the times in his search for truth, and brought little save grievous disappointment to the trustful but suffering patient. Traditionalism so bound the profession to error that even the most independent of its thinkers could scarce cast off its fetters. As a consequence darkness seemed indeed to enshroud the philosophy and impair the practice of the prevailing schools and systems of medicine at the time when homœopathy had its birth.

It is an old saying that "The darkest hour is just before the dawn." This certainly was verified at the dawn of the new era in medicine. When man felt that all had been for naught, that the truth was ever hidden and past finding out, that human search was in vain, then God found, in the time of man's extremity, the divine opportunity. Hahnemann, the immortal philosopher, physician and reformer, was, in the Providence of God, raised unto the work.

From the obscurity of the poor artist's home this truly great thinker was called to take foremost rank among the ripest scholars of the age. Gifted by nature beyond his fellows, thoroughly trained under the wisest of teachers, loved and advanced in his profession by the kindest of friends and counsellors, strengthened and ennobled by a holy regard for the wisdom and love of the all-powerful Creator, and potently actuated by an undying ambition to serve his fellow-man, Hahnemann was steadily led through years of study, observation and experience to the discovery, practical development and lucid exposition of the only true principle for the guidance of man in the selection and application of drugs for the curative treatment of disease.

On the night of the 10th of April, 1755, in the little Saxon town of Meissen, was born this man at whose advent the very angels might well have sung anthems of praise. And now, at the close of this, the first century of the world's enjoyment of the fruits of his labors, we may well pause to give heartfelt thanks to Almighty God for the blessings thus bestowed.

His finished work was the rich result of ceaseless, untiring

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and intelligent zeal, combined with the most unselfish sacrifice of pride, position and profit, of reputation and friendship, of ease and comfort; and, in return, to receive opprobrium and professional ostracism, with all their accompanying sufferings, trials and poverty. Yet all these he unfalteringly endured because conscience and philosophy proved him right.

During the past summer it was my privilege to visit the birthplace of our Hahnemann. The old house still stands. In an appropriate niche over the doorway rests the familiar face of the world-renowned founder of homœopathy. Close by, in the wall, is a tablet bearing the following inscription: "Hier ward geboren Chr. Fr. Samuel Hahnemann, Der Begründer der Homœopathie, D 10 April 1755." (Here was born Chr. Fr. Samuel Hahnemann, the founder of Homœopathy, April 10, 1755.)

Pilgrims to this little town of Meissen are but few, and the townfolk do not as yet comprehend the honor which is their precious heritage. While thousands crowd to see the mouldering ruins of by-gone ages; stand awe-bound as they gaze upon the very spot where royal murders were committed and high-handed injustice once dared exist, but few are found who seek the place where man's good-will to man led earnest followers of the divine teacher to sacrifice all earthly ambition in an effort to establish heaven-born truth.

With deep regret I learned that this, the first abode of Hahnemann, wherein his early education was received, and his early thoughts, ambitions and aspirations had their birth, must soon be destroyed. The town authorities, having determined upon widening the street, have ordered its removal.

'Tis thus, however, with all things earthly—they pass away; memory, the spiritual, the real, exists forever.

From Meissen we next feel drawn to Leipzig and Cöthen.

Leipzig, that city of hope in his earlier work, that place of bitter disappointment in after time! Here, in 1775, he earnestly entered upon the study of medicine, and here, thirty years later, was published the first copy of *Homœopathic Materia Medica;* the "Fragmenta de viribus Medicamentorum Positivis." Here, in 1811, he qualified himself at the University that he might,

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through public lectures, make known that of which he felt himself but the steward. It was here, in 1819, that he encountered the opposition of the doctors and apothecaries, who, through ignorance and avarice, secured the enactment of a law which prohibited him dispensing his own medicines—thus virtually compelling him to relinquish the practice of homœopathy within the limits of that principality. Again man's extremity proved God's opportunity. When most sorely pressed and hope itself seemed almost dead, help was near at hand. Duke Frederic Ferdinand of Anhalt, himself favorably inclined toward homœopathy, proffered full protection and active assistance, together with residence at Cöthen, to Hahnemann.

In 1821 Hahnemann removed to Cöthen, receiving appointment as physician in ordinary to the Duke, as well as the title and position of Hofrath. The Hahnemann residence at Cöthen is still in good preservation, having undergone no marked change since his removal, in 1835. In this quiet abode "the old sage of Cöthen" spent nearly fifteen years of undisturbed peace.

The trials and persecutions engendered and fostered by the jealousy of ignorant and malignant physicians and apothecaries had embittered his life and impeded the progress of the truth most sorely. These persecutions were indeed the active cause of his frequent change of residence, which, though a severe trial as man counts trials, was, as seen in the light of the present, but a blessing in disguise to the cause that he loved. Each new residence developed some new converts, and thus became, as it were, a nidus from which some truth would spread. "Wander-years" have these years truly been named by our earnest and faithful historian, Bradford. Wander-years indeed! Therein pass in painful review Königslutter, Altona, Hamburg, Eilenberg, Machern, Wittenberg and Dessau, then Torgau, where Hahnemann completed the *Organon*. Then, in 1811, Leipzig, where, after eight years of successful teaching and practice, he, through his very triumphs over disease, incurred the active opposition of those who should have welcomed his discoveries and sought to have learned of his method.

Then was offered that haven of peace, Cöthen. Here ended

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forever his wander-years. A great serenity settled upon his life; a restful quiet such as he ne'er before had enjoyed. These years of undisturbed work resulted in rich fruitage to the cause of homœopathy. During this period the philosophy as taught in the *Organon* and *Chronic Diseases*, and the materia medica as found in the *Materia Medica Pura* and in the *Chronic Diseases*, received careful revision, emendation and augmentation at his hands.

With feelings akin to reverence I stood within the old home of the master at Cöthen. Here are the rooms wherein he sat, where he loved to impart those gems of wisdom to his willing disciples. Here, too, the garden wherein he loved to rest and discourse upon the great theme of his life. Here one pictures the philosopher in earnest study, searching after the true in the healing art. There the trained physician weighing with almost superhuman care every symptom, and noting with scrupulous accuracy every modifying condition as observed in each individual case of disease. Near by is the room where his medicines were prepared—just beyond the garden, where still we find the little summer-house covered with its grand old ivy. All seem hallowed by the memories of one who throughout his fruitful life sought but the good of his fellow-man; one who in life and in death gave to God the glory.

We leave these sacred precincts with hearts overflowing in gratitude to the Supreme Ruler for the peaceful years here vouchsafed to our Hahnemann.

Some, even among those here this evening, may ask: Why this unstinted praise? We answer: It is but meet to give praise for the perfection of his work, and the richness of the inheritance which he bequeathed to his fellow-man—the inheritance, HOMŒOPATHY. The importance and perfection of his work is evidenced in the fact that Hahnemann stands alone in having developed a philosophical system, embracing a correct method for the study of the very principle of the diseased action in strict corollary with medicinal action in its various phases, and especially with reference to the new method which he introduced for the study of the curative power of each individual drug.

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Not to weary you with a lengthy dissertation upon the principles first practically taught by Hahnemann, we will summarize the more important distinctive features of his work as follows:

1. The establishment of a system whereby a speedy, gentle and permanent restoration to health may be accomplished in the shortest, most reliable and safest manner, *according to clearly intelligible principles.*

2. The development of a correct idea of disease as found in his teachings in regard to the dynamic nature of disease. The relationship between the force and tissue-changes. The method of reaching a correct knowledge of what is curable in disease in general, and in each individual case of disease in particular. He gave to us a true "Philosophy of Disease." All his teachings were made practically useful through his original and comprehensive instructions with reference to what may be observed in disease, and how such observations and investigations must be made.

3. A comprehensive method for ascertaining a correct and full knowledge of the scope of action and the curative power of each drug, *i.e.*, the "Philosophy of Drug Action," practically developed in the proving of drugs upon the healthy, thus making it possible for the physician to be governed by distinct and demonstrable reasons in his application of a given drug to a given diseased condition.

4. The recognition of the duty and the responsibility of the physician to strictly observe and systematize all matters in reference to hygiene, thus leading directly to the development of a correct "Philosophy of Health." The physician, says Hahnemann, is the guardian or preservator of health.

5. The Law of Similars.
6. The Single Remedy.
7. The Minimum Dose.

} The Philosophy of Therapeutics.

These constitute the essential and well-defined features of true Hahnemannian homœopathy.

While physicians may differ in regard to some of the minor points in Hahnemann's philosophy, and though some of Hahnemann's theoretical explanations are not in accord with pres-

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ent scientific views, it nevertheless remains an incontrovertible truth that science confirms every important principle presented by Hahnemann. The theoretical explanations he offered but tentatively, expressly stating that he attached but little value to such explanations.

The Hahnemannian views gain ground as science makes progress. The philosophy of disease is gaining in acceptance as it is better understood; his philosophy of drug action is practically accepted; his teachings upon the subject of hygiene and sanitation are to-day reproduced under other authorship; and his philosophy of therapeutics, after the trials of a century, stands to-day unshaken.

They all have so impressed themselves upon the entire body medical that though the very spirits of darkness were actuating those who refuse to see, and who during the past century have persistently sought to weaken the foundations of our science, yet must their efforts prove futile. Confusion will be their portion.

Well may we say, in the words of Dr. Watson, the eminent Scotch divine, "It is a long battle between a handful of faithful men and the desert, and too often the desert has won." But let us take heart. "No one need be alarmed, for there is good reason to believe that the end will be the toleration of a noble science and the re-establishment of faith. When workmen come with pick-axe and shovel it is either to destroy or discover, and the aim of present thought is discovery." Let us hope that the same may be said of the science of medicine as he asserts with reference to theology.

In this connection we may observe that Hahnemann's teachings begat the disposition to independence in thought. It was, indeed, the very spirit of the master himself, and must find expression in the mental life of every earnest disciple. The writings of our early homœopaths abound in evidence of such freedom. When judiciously employed such untrammelling of thought is both wise and wholesome, and therefore must tend toward the advancement of knowledge and the establishment of truth. Freedom of investigation and judgment must ever be held inviolate; though, on the other hand, wilful or careless

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error deserves unmeasured condemnation. The disposition to overlook or ignore that which is demonstrably true in order that some pet theory may be sustained, as well as the selfish endeavor to overthrow or supplant the results of the investigations of others rather than assist in developing and extending, or in defining and delimiting them when they are obviously in the line of the truth, is reprehensible in the extreme.

Just here it may not be amiss to call attention to a present palpable fault, namely, the increasing disposition to an ill-timed effort at delimitation as evidenced in the multiplying of brief works on therapeutics and unduly abridged and condensed forms of materia medica to the exclusion of the more developed and more comprehensive works. Such abridgment is no doubt useful in its way, but the time is not yet ripe for much thereof. Harvesting is beginning before the grain has fully ripened. Philosophy is always hungry for facts, but a true philosopher wants ripe facts; he can bide the time of the harvest rather than garner imperfect grain.

An honest and intelligent search for the philosophic solution of problems still in doubt is absolutely necessary to success. This, however, is just the opposite of that easy "ready-to-wear" method of practice, the coveted prize of ignorance and indolence. All hail, then, to every true laborer in the vast domain of science, and especially to those in the field of practical medicine. Many minds need engender many thoughts, while law must correct, harmonize and unify all.

During the past quarter century many in our school have been engaged upon a more or less worthy critical study of the philosophy of medicine; many more upon the more practical work of drug-proving and therapeutic individualization. A strained and labored effort at originality and a wanton disregard of obvious facts have rendered nugatory the work of many of the former, while lack of intercommunication among the latter has seriously impeded the progress and impaired the results of their studies. Concerted effort must be had if great progress is to be made.

Though many interesting experiments have been recorded, I will detain you but a few moments in order to call attention to

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a series of experiments which have engaged the attention of our German colleagues during the past six or seven years.

It was my privilege, August last, to attend the meeting of the Homœopathischen Centralvereins Deutschlands held at Nürnberg. At an informal meeting preceding the regular assembly my attention was called to the topographical delineation of the Weihe'schen pain-points. This work is the result of a system of provings with special reference to the discovery of certain objective painful spots said to be invariable in location and characteristic in each remedy. These "pain-points" differ from points of pain experienced by the patient, in that they are distinctly objective in character; that is to say, the patient may be entirely ignorant of their existence until demonstrated by the physician through properly directed pressure; hence they are spoken of as "*objective pains.*"

A number of interesting experiments confirmatory of the utility of these points in the selection of the curative remedy were made in my presence. From such demonstrations it seems probable that a useful method is here being unfolded. In its present state of development, however, it is only possible to say that, when the symptoms indicate a given remedy homœopathically, the Weihe'schen pain-points often seem to confirm the choice. This method may be utilized in differentiating two or more partially indicated remedies in cases marked by a paucity of symptoms.

Thus between hepar and nux vomica, or between bryonia and kali carb. According to Dr. Weihe, the pain-point of hepar is found on the anterior axillary line between the third and fourth ribs, right side, while nux vomica is characterized by a pain-point at the junction of the middle axillary line with the lower border of the thoracic wall, right side. The pain-point of bryonia lies about midway between the lower costal termination of the mid-axillary line of the right side and the umbilicus. Kali carb. lies on the anterior axillary line, between the fifth and sixth ribs, on the left side.

About ten days ago I made choice upon the pain-point of kalmia at the centre of the upper border of the areola of the left mamma, over against cactus gr., at the centre of the outer

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border of the areola, same side; these points were about two inches apart. The patient was suffering quite severely from angina pectoris. Relief was both prompt and efficient.

The members of the Centralverein are deeply interested in this work, and believe they have positively defined nearly two hundred such pain-points. In the printed pamphlets of 1891 and 1892, edited by Doctor Göhrum, 163 such points are defined, and others have since been added. From the demonstrations which I witnessed it would appear that the possibilities would warrant more extended observation and investigation by unprejudiced critical observers.

Another thought worthy of note, brought out in conversation with our German colleague, Dr. Franz Erwein, graduate of Hahnemann College of Philadelphia, was the enhanced efficacy of our homœopathic remedies when administered hypodermatically. The doctor instanced some advanced cases of tuberculosis markedly benefited through such use of balsam of Peru in the fourth decimal aqueous solution. The injections should be repeated about twice each week until reaction seems fully developed. During my visit in Mainz, I was enabled to confirm the doctor's claim with sufficient fulness to feel warranted in the employment of this mode of administration of the similimum where occasion offered.

Doctor Erwein also reports the most satisfactory results, in severe forms of diphtheria, from the hypodermatic use of the cyanide of mercury in the fourth decimal dilution. One case, cited in a letter which I have just received, seemed indeed beyond the power of all ordinary modes of administration. The membrane filled the throat and nose, swallowing seemed impossible, systemic poisoning was intense, the heart's action was extremely weak, and death was momentarily awaited. The fourth dilution of the cyanide of mercury was given hypodermatically, and was followed by prompt and continued improvement.

Though the experiments have been limited in number, the results have been of a character that should bespeak for this mode of administration of our remedies the careful consideration of the profession.

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Regarding such hypodermatic use of our remedies, there can be no valid objection. Even Hahnemann tried various plans: for instance, by the mouth, dry; also in water, with charcoal or brandy to prevent putrefactive changes; by olfaction; and at times he even recommended the direct application to the skin. The mode of administration of the remedy may vary, being still empirical; the method of selection must remain practically the same, being established under law.

Hahnemann discovered the law, and developed the method for its successful application. It now rests with those who would be his worthy disciples to take up the work where he, through the limitations involved in mortality, was compelled to lay it down.

This sacred obligation rests upon every conscientious physician. Every day must he dedicate anew, whatsoever of time or talent may be in his keeping, toward the perfection of our knowledge of the divine art of healing. He must strive earnestly for that perfect ideal which Hahnemann with prophetic mind foresaw, but which his own lifetime though prolonged beyond the allotment of ordinary man, was still far too short to realize.

As discoverer and expounder of the unalterable law of cure, and as the author of a perfected method for ascertaining the curative powers of drugs, Hahnemann stands foremost in philosophy and practice among the medical teachers of the world. It was his lot to suffer as reformers ever suffer. Opposition, persecution, calumnies, and finally ostracism were heaped upon him. Non-receptive minds and selfish souls failed to share his enthusiasm, and often thwarted his most painstaking efforts to advance our knowledge of the means for alleviating the sufferings of mankind. Nevertheless, though hampered by poverty, misunderstood by his friends, deserted by his medical associates, misrepresented and vilified by enemies, hindered in his investigations and estopped in his practice by most unjust laws instigated by and enacted through the malevolent efforts of jealous and vicious physicians and apothecaries, he, with unselfish zeal, persevered in his God-appointed task until the glorious light of God-given truth shed its beneficent rays upon an ignorant and suffering world.

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THE TRUE STORY OF HAHNEMANN'S GRAVE.

BY THOMAS LINDSLEY BRADFORD, M.D., PHILADELPHIA.

It was known that Hahnemann's body was buried in the Montmartre Cemetery, that is by people who knew anything about the matter; I even had a wood-cut of the grave which had been published in Schwabe's *Homöopathischer Kalendar* for 1892. But I was not quite sure that the picture was a correct one, and as I wished to be certain it was correct, I gave Mr. Charles Platt, Professor of Chemistry in the Hahnemann Medical College, who was just about to sail for Paris, a copy of the picture, with directions as to the location of the grave, and later, at his request, forwarded him the following data in proof that Hahnemann really died and was buried in Paris:

In 1843 the French physician Jahr, writing to the *Allg. hom. Zeitung*, announces that Hahnemann is dead, and goes on to say that he was called to the house by Madame Hahnemann, and saw him lying cold and stiff on his bed. (See *Allg. hom. Zeitung*, vol. xxiv., p. 237; Bradford's *Life of Hahnemann*, p. 417.)

Dr. Suss-Hahnemann, writing to the *British Journal of Homœopathy*, May 30, 1865, says: "Unfortunately I was only present at the very last moments of my grandfather, not even on the eve of his death, although my late mother and I had arrived in Paris already a week previous to this sad event." This does away with the story that he died at Nice. An account of his death appears in the *British Journal* for October, 1843, as follows: "Samuel Hahnemann died in his 89th year at the house in the Rue de Milan, at five in the morning, after an illness of six weeks. His remains are at present laid in Madame Hahnemann's family vault at Montmartre, but will probably ere long be transferred to Germany."

In 1878 Dr. Gailliard, writing in the French journal *L'Homœopathe Militante*, says: "Where are buried the last mortal remains of the founder of homœopathy? At Paris, it is thought, but all the world is ignorant in what cemetery. One of my confrères in Paris assured me, fourteen years ago, that the body of Hahnemann had been temporarily laid in the tomb of the celebrated painter Lethière.

"At the meeting of August 14th of the last International Homœopathic Congress at Paris, Dr. Van der Heuvel, of Antwerp, presented in the name of the Belgian Homœopathic Society a motion to erect a monument upon the tomb of the founder of the homœopathic school. The president, L. Simon, then said that the place of burial was unknown. Dr. Petit, allied to the family of Hahnemann, certified, on the contrary, at the same meeting, that the ashes of the Master reposed in the same place where Madame Hahnemann had placed them, but he could not specify it exactly. But little more was said.

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"The *Bulletin of the Société Medicale Homœopathique* of France and the *Art Medical* of Paris, for October, announced, over the signature of the pharmacist Ch. Catellan, that Hahnemann reposed in the cemetery of Père-la-Chaise.

"I have sought to decide the question beyond all doubt. I addressed myself to the municipal authorities, and received the following official note:

"'M. Hahnemann, Chretien-Frederic, died the 2d July, 1843, Rue de Helder, No. 11, has been buried, the third of the same month, in the Cemetery of the North (Montmartre) 16. D, 1 Ligne—along by the wall No. 9.

"'Madame Hahnemann, his widow, died May 29, 1878, has been buried in the same place.' It is a concession to perpetuity that there is neither cross nor surroundings, only some flowers that have been there for some months. To homœopaths now it remains to do something.—DR. GAILLIARD."*

Dr. Puhlmann, in the *Leipziger Populaire Zeitschrift fur Homöopathie*, for July, 1893, says: "As early as six o'clock in the morning, in gloom and rain, on July 11, 1843, a funeral procession moved through the streets of Paris to the cemetery of Montmartre. * * * * A monumental stone with the inscription: Chretien-Frederic Samuel Hahnemann, on the left side of Section 16, of Montmartre Cemetery, marks the spot where the deceased was laid in his eternal resting-place. This resting-place, as well as those of many other celebrated men buried in Montmartre, as, for instance, that of the poet Heinrich Heine, belongs to those historic sepulchres that are kept in order at the expense of the Government, when relatives no longer care for their departed."

The *Homœopathic World*, v. 13, p. 349, says: "Early one morning in July, 1843, a common hearse drew up in the court-yard of Hahnemann's mansion; the coffin was quickly lifted into it; as quickly the hearse drove away again. His wife, his daughter, his grandson (Suss-Hahnemann) and a young Dr. Lethière, were the only mourners who followed the hearse, on foot, to the neighboring cemetery of Montmartre. There Hahnemann's coffin was pushed in a most unseemly manner into an old vault, where two coffins had already been placed by Madame Hahnemann. There was no funeral ceremony whatever; no funeral rites; no blessing of the distinguished dead." (Probably written by Suss-Hahnemann. See Bradford's *Life*, p. 424.) Suss-Hahnemann, writing over his own name in the *British Journal*, vol. 22, p. 679, says: "The coffin was deposited and is still, at the present moment, in an old vault where his devoted wife had already deposited the remains of two aged friends."

In Schwabe's *Kalendar*, in which the picture is published, is the following: "The grave of Samuel Hahnemann is at Paris, at the Cemetery Montmartre, and was erected by his second wife, Melanie, whose maiden name was d'Hervilly Gohier. The monument bears the inscription: Chretien-Frederic Samuel Hahnemann. It is one of the so-called historical graves there, which are preserved at the expense of the Government when relatives will no longer care for them. Not far from this grave, in the 16th department of the Cemetery Montmartre, to the left side, there is the monument of a not less celebrated German, who died in Paris, that of the poet Heinrich Heine."

Dr. Alexander Villers, of Dresden, writing to me in 1893, says: "Frau von Bœnninghausen lives at Münster, Germany, but I think it is not worth while to write to this lady, who is decidedly unfavorable to every suggestion concerning

* *L'Homœopathe Militante*, October, 1878, vol. i., p. 456.

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her step-father Hahnemann. I have tried in vain to get from her the permission to put Hahnemann's name on his burial-place. She declined in a very unkind way, so that now it is rather a difficult thing to find out where Hahnemann lies."

I received the following letter from Prof. Platt in May: "This afternoon I consecrated to the memory of Hahnemann, beginning with a visit to the cemetery. I enclose a certificate of inhumation (undated), which you will see corresponds with the direction which you gave me; an examination of the facts, however, shows this to be false. No. 9, 16 division, is the grave of Hahnemann's widow, and bears the following inscription: 'Marie Melanie d'Hervilly, Vve. de Chretien-Frederic Samuel Hahnemann, nee le 2 Fevrier 1800, decedee le 27 Mai 1878. Maman—amour—toujours.' The inscription is much worn. A number of wreaths are placed upon the tomb. The grave of Hahnemann himself is No. 8 of the same line, has no inscription whatever, other than the following letters and figures at the base: 'C. P. 324—411—1832–1834.' This plot is entered in the books of the cemetery in the name of Lethière, but an investigation of the books of that date showed this to be the true resting place of Hahnemann. Your small photograph is a true representation of the tomb, and this is fortunate, as I have not been able to obtain a photograph, and an attempt to sketch it for you resulted in a threat of arrest unless I destroyed the sketch on the spot. It is against the law to make any sketches in the cemetery. The tomb is covered with a rusty tin roof, badly broken in places, surrounded by a rusty iron railing, enclosing a few weeds and the inscriptionless tomb. On the cross-bar hang six black wreaths, formerly yellow, probably those visible in your photograph. I discovered an interesting fact regarding the grave, and that is that the present tomb occupies more space than has ever been paid for; that 110 francs is still owing to the city of Paris, and that they will shortly tear up the tomb unless this is paid. It so happened that while I was in the office of the cemetery, I heard the order to that effect. Every effort has been made by the authorities to find some one to pay this account, but for the past year or so they have lost track of all parties concerned. Now, here is a chance for some of the Philadelphia societies to distinguish themselves;

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110 francs ($22.00) to save Hahnemann from being disinterred! Or, to go a little further, I find that 110 francs, in addition, will put a new railing around the tomb and a new roof overhead. Thirty francs per year will maintain the tomb in perfect condition. Here there is an outlay of 220 francs ($44.00) and 30 francs ($6.00) per year afterwards. Is not the result worth this much? Of course, I presume there will be a few francs in fees necessary, but the present outlay would certainly not exceed $50.00.

"Now as to the houses where Hahnemann lived. No. 11 Rue de Helder is the Hotel Richmond, where, I am told, Hahnemann lived shortly before his death. As I understand the proprietaire, Hahnemann did not die in the house, but at Nice. The hotel is first-class and in excellent condition. No. 1 Rue de Milan is on a small street leading off, I believe, from the Rue d'Amsterdam, and in the vicinity of the Gare St. Lazare (Gare de l'Ouest)."

This letter from Prof. Platt was received at Hahnemann College, and before I went home I visited Dr. Raue. He was very indignant that such a thing could be, that while a grand monument was being raised to the memory of Hahnemann his grave should be in such a condition; it was the last time I ever saw him, and I shall not soon forget the interview. From there I went to the home of Prof. Pemberton Dudley, Dean of the College, and told him of the circumstances. He said that Hahnemann College must pay the debt and secure the bones of the master from desecration. And Profs. Dudley, Mohr and Goodno, meeting at the college, decided to assume the responsibility, and authorized Prof. Mohr to write to Prof. Platt to use his judgment and to take such measures as he deemed fitting to care for the neglected tomb. I wrote to Prof. Platt as follows: "I have seen Prof. Dudley this afternoon and he tells me that Hahnemann College will write, through Prof. Mohr, giving you *carte blanche*. I have explained it all to Prof. Dudley, and we wish you to act as you think best. If the body of Hahnemann is in this grave and can be protected we wish to do so and at once. To my mind there is no doubt that Hahnemann's bones do lie there. Dr. Lethière was a young

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man who affected homœopathy and who attended Hahnemann in his last illness, and who was one of the four who followed him to the grave."

The next letter from Prof. Platt is dated May 22d, and is as follows: "Just a word to-day to tell you that I have called on several of the French physicians, but apparently they do not know as much about Hahnemann's residences or life here as I do. Knew nothing about Rue de Helder or Rue de Milan, and *did not know he was buried at Montmartre.* No. 1 Rue de Milan is the Hotel de Rouen, a third-class hotel on the corner of the Rue de Milan and Rue de Clichy. The ground floor is occupied by a taxidermist, and carries the sign of *Histoire Naturelle.* The street itself is on the hill above the Gare St. Lazare, and runs from Rue d'Amsterdam to Rue Clichy; many of the houses are first-class, as, for instance, No. 3, next to the Hotel de Rouen. During Hahnemann's life this building was known as the Hotel Hahnemann; at that time there was no opening on the Rue de Clichy, the entrance being through a garden now belonging to No. 3."

I had given Prof. Platt a letter of introduction to Dr. R. E. Dudgeon, and had also suggested to him that he visit Dr. Suss-Hahnemann in London. He wrote to him, and in a letter dated June 24th, gives Dr. Suss-Hahnemann's account of his grandfather's funeral. The following is a verbatim copy of Dr. Suss-Hahnemann's letter:

"14 HIGHBURY CRESCENT, LONDON, 21 June, 1896.

"*Dear Sir*, Dr. Dudgeon has sent me your letter to him inquiring which is the tomb where my grandfather is buried. I am most willing to give you all the information, as I was present at the funeral. My grandfather had the poorest and meanest funeral; he was buried very early in the morning; unfortunately it was raining all the time. Whilst the undertaker-men were carrying the coffin down the staircase of the hotel in the Rue Milan there occurred already a very serious altercation between Madame Hahnemann and the men, for they had put down the heavy coffin too quick on one of the steps and Mme. Hahnemann feared, not that the coffin would be injured, but that the staircase might be damaged, expressing thus more

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anxiety for the staircase than for the coffin. We all walked behind the funeral car, a very poor affair, to the Cimetière Montmartre. Arrived at the open grave, there was another disturbance. It was an old brick grave with two coffins already in it. I ascertained that one coffin contained the body of a M. Gohier and the other the body of a M. Lethière. My grandfather's coffin being too large would not go into the grave; the men tried for some time to push it into it; at last they were obliged to tear off the top coping-stone, and thus at last poor Hahnemann came to rest and peace. The grave is that of No. 8, and if it could be opened my grandfather's coffin would be found to be on the top just above the coffin of M. Lethière. It was a very sorry affair, the burial of my grandfather. Mme. Hahnemann had obtained permission to keep the body above ground for a fortnight as she had embalmed the body, at which operation I was also present. Thanking you for the great interest you take in this affair I remain, yours sincerely,

S. HAHNEMANN, M.D."

The following is Prof. Platt's own account of his experiences in rescuing Hahnemann's grave from desecration: "Armed with a location [16 D, Line 1, No. 9] and with a picture of the supposed tomb, both provided by Dr. T. L. Bradford, of Philadelphia, I visited the cemetery of Montmartre on May 15th. Having traced out the grave according to direction, it was discovered that the location above given did not correspond with the picture, the latter being a reproduction of No. 8, not No. 9. Inquiry at the office of the cemetery at first confirmed No. 9 as the true Hahnemann plot, but further investigation, both at the grave and in the office, showed that No. 9, containing the body of Madame Hahnemann, had been purchased subsequently to Hahnemann's death. No. 8 was entered in the cemetery books in the name of Lethière, the original purchase dating from 1832. The fact that Madame Hahnemann had known Lethière, and that young Dr. Lethière had been one of the few to attend Hahnemann's funeral, led me to the belief that possibly No. 8 was the true resting-place of Hahnemann—a supposition afterwards confirmed.

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"During the prosecution of the inquiries at the office, I overheard an order for the destruction of No. 8. I was told that this plot had never been completely paid for, and that the tomb was now to be removed. Believing, as I did, that it was the tomb of Hahnemann, I obtained a delay in the proceedings until the Hahnemann College of Philadelphia could be communicated with and the state of affairs presented to the faculty. Upon return mail, authorization was sent to me by the Registrar, Prof. Charles Mohr, in the name of the faculty, to do whatever I might consider best in the matter.

"The cemetery authorities had at first given me the impression that they possessed an entry of Hahnemann's burial in No. 8; but this I now found to be premature, as they had not, at that time, discovered any record to that effect. For the moment, therefore, further inquiry was abandoned, but having, in the meantime, communicated with Dr. Bradford, I received a few weeks later a complete statement of the facts, so far as known, relating to Hahnemann's burial. With the great assistance thus afforded, the cemetery was again visited, and a thorough search of the records made. On the certificate of inhumation of Lethière was found a note in red ink, across one corner, referring to an interment on the 11th of July, 1843; and finally, in one of the old books of the cemetery, an entry was discovered recording the burial of Chretien-Frederic Samuel Hahnemann, age 89, on July 11, 1843. The one link still lacking in the chain of proof was supplied by the receipt of an interesting letter (quoted elsewhere) from Dr. Suss-Hahnemann, of London. Present at his grandfather's death and burial, his certification of No. 8, the Lethière plot, as the true one, left no further room for doubt. Steps were at once taken to free the tomb from debt to the city. With my wife as interpreter, papers were obtained from the cemetery authorities, were filed at the Hotel de Ville, payment was then made for the plot, and the receipts finally registered at the offices of the cemetery. At the same time orders were given for the repair of the tomb, for the removal of the dilapidated roof of zinc, for the polishing of the stone, and for the repair and painting of the surrounding railing. I was obliged to leave Paris on June 26th, before these

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alterations could be finished, but Dr. François Cartier, to whom I had the pleasure of showing the tomb on June 25th, kindly offered to see that all was properly executed; and I have since been informed by him of the successful completion of the work."

The following official document has recently been received by Prof. Platt from the Prefecture at Paris, and has been filed in the archives of Hahnemann Medical College of Philadelphia:

"Direction des Affaires Municipales. Bureau des Inhumations. Cimetière du Nord. Addition du °. m. 22 cent. à une concession perpetuelle de trois metre. Republique Francaise. Libertê, Egalité, Fraternité, Préfecture de la Seine.* Le Prefet de la Seine, Vu le décret du 23 prairial an XII sur les sepultures;

"Vu les bons de concession en date des 23 Avril 1832 et 20 Sept. 1834. établissant qu'il a été fait à Mme. Vve. Guillon-Lethière concession de trois metres superficiels de terrain dans le Cimetière du Nord;

"Vu le rapport de M. le Conservateur du Cimetière du Nord duquel il appert qu'à la suite des opérations cadastrales exécutées dans le dit Cimetière, il a été reconnu que la concession ci-dessus, au lieu des trois mètres superficiels concédés, occupait une surface de trois metres 22 cent'rs faisant ressortir une anticipation de 0^m 22 centiemes dont le prix, soit cent dix francs, au tarif alors en vigueur, n'avait pas été acquitté;

"Vu le récépissé délivré par le Receveur Municipal le 25 Juin 1896, duquel il appert que M. Charles Platt agissant au nom

* THE PREFECT OF THE SEINE.—In accordance with the decree of the 23 Prairial, year XII., on Sepultures; In accordance with the articles of concession dated April 23, 1832, and Sept. 20, 1834, establishing that there has been made to Mme Vve Guillon-Lethière a concession of three surface metres of land in the Cemetery of the North;

In accordance with the report of the Conservator of the Cemetery of the North, by which it appears that in the course of the monumental construction undertaken in said cemetery the above concession, in place of the three surface metres conceded, occupies a surface of three metres 22 centimetres, making an excess of 0 metres 22 centimetres the price of which, one hundred and ten francs according to the tarif then in operation, has not been paid;

In accordance with the receipts given by the Receiver Municipal on the 25th of June, 1896, by which it appears that M. Charles Platt, acting in the name of those having the rights of Mme Vve Guillon-Lethière, has paid to the Municipal Bureau, for the purpose above mentioned the sum of one hundred and ten francs, divided as follows:

Part reverting to the City of Paris, ...	88 francs.
Part reverting to the Public Works, ...	22 "
Total, ...	110 francs.

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des ayants droit de Mme. Vve. Guillon-Lethière a versé a la Caisse Municipale, aux fins ci-dessus, une somme de cent dix francs ainsi repartie.

Part revenant à la Ville de Paris, ...	88f.
Part revenant à l'Assistance publique, ...	22f.
Total égal, ...	110f.

Arrete.

"ART. 1. Il est fait concession aux ayants droit de Mme. Vve. Guillon-Lethière, représéntés par M. Charles Platt de 0^m 22 *Ces.* de terrain dans le Cimetière du Nord par addition aux trois Mètres concédés les 23 Avril 1832 et 20 Sept. 1834.

"ART. 2. Les terrains ainsi concédés ne pourront jamais étrevmis dans le commerce et ne sont transmissibles que par voie de succession ou partage ou de donation entre parenta.

"ART. 3. Les frais de timbre et d'enregistrement du présent arrété, montant a la somme de 9f. 60c. (soit 3f. 60c. de timbre et six francs d'enregistrement) sont á la charge de M. Charles Platt.

"ART. 4. Ampliation du présent arrété sera addressée;

"1. á.M. Charles Platt, Chimiste au College de Hahnemann a Philadelphia (E. U.) au nom des ayants Droit de Mme Vve Guillon-Lethière.

"2. á.M. le Directeur de l'Administration de l'Assistance publique;

"3. á.M. le Conservateur du Cimetière du Nord.

Fait à Paris le 11 Juillet 1896. Pour le Préfet de la Seine, Le Conseiller de Prêfecture délégué. Signé Laty.

Pour ampliation; Pour le Secrêtaire Général le Conseiller de Prefecture Délégué. Enregistré à Paris, Bureau des Actes

Be it decreed:

ART. 1. Concession is hereby made to those having the rights of Mme Vve Guillon-Lethière, represented by Charles Platt, of 0 metres, 22 centimetres of land in the Cemetery of the North, in addition to the three metres conceded April 23, 1832, and Sept. 20, 1834.

ART. 2. The land so conceded is never to be exchanged by sale and is not transferable except by inheritance, by division, or by gift between relatives.

ART. 3. The expenses of stamp and of registration of the present decree, namely 9 francs 60 (3 f. 60 for the stamp and 6 f. for registration) are paid by M. Charles Platt.

ART. 4. Copies of the present decree will be sent:

1st, to M. Charles Platt, chemist of the Hahnemann College, Philadelphia, U. S. A., in the name of legal representative of Mme Vve Guillon-Lethière.

2d, to the Director of the Administration of Public Works.

3d, to the Conservator of the Cemetery of the North.

Done at Paris the 11th of July 1896, for the Prefect of the Seine, Counsellor of the Prefecture by Appointment. Signed: Laty.

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Administratifs le vingt trois juillet 1896 fs, 5.79. Récu six francs décimes compris signé illisible."

Hahnemann's tomb has been put in repair and Prof. Platt holds receipts from the marble-worker who made the repairs. It may be mentioned that the receipt given by the Municipality of Paris for the payment of 119 f. 60 is made out: "*Received of Charles Platt for the Hahnemann College of Philadelphia, the sum of* 119 *francs*, 60 *centimes, for a concession in perpetuity in the Cemetery of the North.*" It has been given as a legal opinion that Prof. Platt, by the payments made, has really bought the plot in which Hahnemann's body rests, and that as he was acting for the College, Hahnemann College to-day owns the tomb of Hahnemann. In any case it is doubtful if any one can now disturb the body.

And now let us remember that to Prof. Charles Platt is due a very great amount of gratitude, inasmuch as he has roused interest in the neglected grave on the hill at Montmartre, and removed the danger of future interference with the remains of one of the greatest of human benefactors.

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PAPERS.

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REPORT OF THE BUREAU OF GYNÆCOLOGY.

Fixation of the Uterus in Retro-Deviations, by J. H. Thompson, M.D.
As to the Wheel, by Anna C. Clarke, M.D.
The Development of Salpingitis in Young Women, by B. F. Betts, M.D.
Certain Mental and Physiological Changes Following Removal of the Ovaries, by G. W. Smith, M.D.
A Remedy Useful in Climacteric Flushing, by Emma T. Schreiner, M.D.
A Synopsis of Operations in the Gynæcological Clinic of the Hahnemann Medical College During the Session of 1895 and 1896, by John E. James, M.D.

FIXATION OF THE UTERUS IN RETRO-DEVIATIONS.

J. H. THOMPSON, M.D., PITTSBURG.

FIXATION of the uterus in retro-deviations, as accepted by all who are interested in the furtherance of the science of gynæco logical surgery, is the condition ever to be desired.

In these days, when so many new and unique operations are urged upon the surgeon in such rapid succession, we prefer to select from those in which the methods of fixation has succeeded in interesting a large number of the most eminent surgeons of the profession in this country and Europe, on the strength of the favorable results obtained with them by the high authorities which I shall quote. It has become the object of exhaustive tests in all the large hospitals, dispensaries, and in private practice.

In many instances the favorable results so far obtained have led to the regular employment of these operations for the relief of retro-deviations, as shown by the fact that they are even at this early date (after their introduction here) in quite active demand.

The most searching theoretical and practical tests are respectfully requested of all our gynæcologists, and we trust they

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will publish their results in the recognized medical journals of the profession.

Ventro-fixation: "*Synonymous,*" *gastro-hysterorrhaphy, gastro-hysteropexy, gastro-hysterosynaphy, indirect, direct lateral* and *direct median.*

Illustrative Cases.—Methods: Olshausen, Czerny, Leopold, Saenger, Kelly, Koeberle, Polk, Wylie, Klotz, Mundé.

Owing to the close association of retro-versions and retro-flexions, and the fact that the treatment of both has much in common, I have placed them together under the head of deviations yielding to treatment by fixation.

I have observed that retro-flexion of the uterus is frequently, in fact in the greater majority of cases, produced as a result of a retro-version.

Deviations occur in single women, as well as those who have borne children. Among the single women I find it more frequent. We find both the congenital and acquired. In those cases in which deviations are recognized in early life I believe there is a history of a lesion brought about by the lack of development.

The secondary development taking place at puberty, owing to the increase in weight of the body and fundus, causes displacement of the body of the uterus, and the cervix being held in place by the resisting virgin vagina, the flexion is produced.

When it occurs after childbearing, without a doubt retro-version occurs first; the cervix meeting resistance from the anterior vaginal wall and partly distended bladder in front, the flexion is produced. At the point of flexion the pressure at that point causes atrophy, thereby gradually increasing the flexion.

There is no question in my mind but that most of the acquired cases are the result of some lesion or excess of involution at the junction of the body and cervix, and the walls of the uterus being thus weakened, at that point, permits the uterus to deviate.

Under the head of acquired and uncomplicated cases palliative treatment, persisted in long enough, will usually give relief.

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Among the congenital there will be found cases which do not yield to palliative treatment.

A few of the most distressing symptoms may be ameliorated by the use of a mechanical support, but as soon as this is removed the deviation will return.

The resistance of most cases to treatment consists of a rigid state of the posterior wall of the vagina, which prevents the use of a pessary that would extend far enough back to be of service in supporting the fundus. Pessaries frequently aggravate such cases.

The different methods of fixation which I will describe as to the operative treatment are especially applicable to backward and downward deviations.

In ventro-fixations of the uterus, or gastro-hysterorrhaphy, it may be well to mention that the first operation of this kind was performed on March 27, 1869, by Koeberle, and later systematized by Olshausen after his communication to the Medical Congress at Berlin, in 1888.

The foremost in this country in popularizing it is Kelly, Polk, Wylie and Mundé. Not until 1888 did it receive the approval of the general profession, at which time its value was fully established.

In describing the technique of the operation for ventro-fixation I shall endeavor to give as simple a description of it as possible.

Having the patient properly prepared, proceed to open the abdomen in the median line, as for oöphorectomy. In cases where there is the slightest indication of an old endometritis the operation should always be preceded by curettage as a preliminary step.

After the rupture of adhesions that may be present the uterus is brought forward and transfixed through the fundus by a strong silk ligature, which is preferable to the tenaculum. Traction applied to the tenaculum frequently tears through the wall of the uterus, producing an ugly, lacerated wound, open for the absorption of septic matter.

The silk ligature is more convenient to work about in case the appendages are to be ablated. As to the removal of the

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appendages, this is according to the indications found in each individual case.

In all cases where an ovary or ovaries are diseased or prolapsed, it is advisable to remove them *en masse*. After replacing a prolapsed ovary removed from a bed of adhesions, which is generally the rule in all such cases, it is not advisable to let it remain, even if healthy, as it is liable to soon become misplaced and caught in the same trap of adhesions from which it had been relieved, squeezed and pinched by the healing and cicatrix of the same.

In fixation of the uterus to the abdominal wound, I prefer the continuous hem suture of a strong chromicised catgut ligature when properly prepared and aseptic. Any indicated operation having been completed, it but remains to fasten the uterus up. A portion of the anterior surface of the uterus, from the bladder junction to the tubal openings, should be scarified in the middle for a width of one-half inch, and a similar strip on the peritoneal surface of the bladder should be treated in like manner. The scarification should not be deep enough to cause bleeding, the uterus being strongly drawn up by the transfixed ligature, and an assistant raising the organ with his finger in the vagina.

With a heavy curved needle, armed with strong, chromicised catgut, pass through the lower part of the wound, including the serous, fibrous and muscular tissues of the abdominal walls, in such a way as to establish a permanent support. Starting from this point, rapidly make a spiral ascending hemstitch, including all of the tissues (except the skin and subcutaneous cellular tissue), including the superficial layers of the uterus in the median line, and then through the opposite lip of the incision until three to five stitches have been passed, which, as a rule, are sufficient.

The uterus being fixed to the abdominal wound, the catgut sutures are tied. In closing the abdominal wound use a continuous suture of fine chromicised catgut for uniting the peritonæum, and include with this suture the muscle, but omit the fascia. Next, deep, sustaining, interrupted sutures of silk-worm gut are inserted. These are made to include the skin, fascia

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and muscular layer. Before tying these, the fascia is united separately with a continuous suture of the same chromicised catgut. The silk-worm gut sutures are now tied, being accurate in keeping the skin in good apposition, the surface washed and dried carefully. The ideal dressing for the wound is an antiseptic dressing, one that will prevent germ-propagation, with firm compress. Since adopting this method of closing and dressing abdominal wounds they have given me no trouble whatever, but have invariably healed by first intention.

The bladder should be kept fairly empty for two days, by having the urine drawn every four hours. This operation does not fasten the uterus in an abnormal position, but simply obliterates the utero-vesical pouch, and the uterus is held in an exaggerated normal position. As to the suturing material to be used, there is no doubt but that the chromicised catgut suture is to be preferred to all others in use. It is well to insert a Hodge or Smith pessary, or support it by an antiseptic tampon, frequently renewed, for at least a month or six weeks, to prevent strain on the sutures and maintain the good position gained.

Keep the patient in an incline bed toward the head, to prevent intestinal pressure.

Olshausen, who invented this operation of ventro-fixation, has done it but eight times in six years; his indications were adherent retro-displacements, which caused much suffering and appeared incurable by other means.

In regard to the results of ventro-fixation, Leopold states that all those complaints which relate to the retro-flexion itself always cease, but that, on the other hand, the nervous hysterical complications do not disappear. In Olshausen's cases they nevertheless disappeared gradually, though after a very long time.

Milandi found that in fifty-four cases of labor at full term, complicated by ventral fixation, eleven required assistance; four, forceps; two, Cæsarian section; four, versions; and one, extraction. If the adhesions to the abdominal wall are too extensive the conditions are like those after vaginal fixation.

Case I.—Mrs. D., æt. 32; mother of four living children; no

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miscarriage; her labors proved to be difficult and complicated. Is distressed with pain in small of back and has a copious leucorrhœal discharge; frequent micturition and constipated. On examination found a retro-deviated uterus, sub-involution, chronic ovaritis, with cystic degeneration and uterus prolapsed to the second degree.

Operated February 25, 1896. Ventro-fixation. Patient made a rapid recovery, leaving her room at the end of three weeks. Examined her one month ago, to find uterus in good position and improvement of all symptoms continued from the day of the operation; also relieved of the various reflex symptoms. Last report she is a perfectly well woman. (Pozzi's method.)

Case II.—Mrs. B., æt. 29; mother of two children; one miscarriage two years ago. She has been a great sufferer from the birth of her first child. Backache, headache, chronic constipation and a very offensive leucorrhœal discharge. On examination discovered a small fibroid tumor on the anterior surface of the uterus near the fundus, also a badly lacerated cervix, sub-involution, a very severe grade of prolapsus and retroflexion.

Operated March 12, 1896, removing the fibroid off the anterior wall, and fixed the uterus in ventral opening at the point of the removed fibroid. Made a rapid and uneventful recovery. Last report states she is relieved of all her pains and aches, and enjoying better health than for many years. (Leopold's method.)

Indirect Fixation.—This method consists of the removal of the ovaries or tubes, and fixing the pedicle in the abdominal wound. This has fallen into disuse, owing to the fact that it sacrifices the ovary or tube, and twists the uterus, causing much discomfort, and often failing to unite. (Koeberle, Klotz.)

Direct Lateral Fixation of the Fundus.—This consists of sutures passed on each side of the uterus, at the end of the fundus, including only the anterior serous layer, being careful to not pierce the tubes or epigastric artery. This has its disadvantages, owing to it leaving an opening between the anterior wall of the uterus and abdominal wall, liable to produce inter-

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nal strangulation. This method is similar to that of Kelly's, and does not need special description. (Olshausen, Sanger.)

Direct Median Fixation.—In this method the fundus of the uterus is fixed in the abdominal wound. The uterus being freed it is brought up, and the sutures passed from before backward, a little outside of the whole border of the wound, through the whole abdominal wall at the level of the fundus. The uterine tissue is pierced in the elevated surface of the anterior aspect of the organ, in a line with the serous membrane, and the superficial layer of the muscle for a distance of one centimeter, and then through the other lip of the wound; but this time from behind forward. A second and third suture is then inserted above, in a line with the insertion of the tubes, for about two centimeters and a third apart. To facilitate adhesions the fundus between the sutures is gently scraped with a bistoury, making a superficial freshening which does not bleed and simply removes the epithelium.

Unite the abdominal wound at that point by tying the three sutures above the abdominal wall.

The abdominal wound that remains unclosed is brought together with interrupted sutures, both above and below.

In case silk or wire sutures have been used, they should be removed at the end of a fortnight, supporting the uterus with a well-fitting pessary to prevent strain. (Leopold, Czerny.)

Anterior Fixation of the Uterus.—By the methods of Alquie, Alexander, Adams. This operation is known as Alexander's operation, although the idea of restoring or correcting retro and downward displacements of the uterus by shortening the round ligament belong to Alquie, of Montpellier. After being introduced into Germany, France and England, it was asserted, after insufficient and unfortunate investigation, that the round ligament was not to be found outside of the inguinal ring. Closer investigations following its introduction has won it a permanent place in the field of gynæcological surgery, and although its precise indications and advantages are far from being correctly appreciated, it has a few most ardent advocates.

As a preliminary step, curetting should always precede the operation.

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Operative Technique.—An incision of two inches is made over and in line with the inguinal canal through the cutaneous and sub-cutaneous tissue down to the muscles, the external inguinal ring being laid bare, the cellular layer cut, the genito-crural nerve exposed and drawn aside, and with a blunt instrument the round ligament sought. It is recognized by its reddish, cord-like aspect, and is then seized with a strabismus hook. The wound being covered with an antiseptic pad, proceed with the opposite side in a similar manner.

There is at times great uncertainty in finding the round ligament, and, unfortunately, the results prove to be absolute failures if the ligaments have not been found. The uterus being replaced by an assistant with a sound in the organ, the operator seizes the ligaments, and with gentle traction draws the uterus close up against the abdominal wall, being careful to evacuate the bladder before attempting the latter. There is absolutely no way of determining the size of the ligament before the inguinal canal is opened. The ligament should be drawn out a distance of about four inches, being careful not to wound the serous membrane. The traction on the ligaments must be the same, applying but little force, especially when reduction is aided by an assistant with sound in the organ. When the uterus is replaced we can easily feel the resistance.

The ligaments are kept moderately tense, and with a curved needle, armed with chromicised catgut, is passed through the external pillar, and the ligament towards its upper border, and lastly through the internal pillar, so that the stump of the ligament is firmly fixed to the margin of the external orifice of the inguinal canal. A second suture is passed through the lower portion of the ligament, and the fibrous cord that is beyond these sutures is cut off. The ring should be closed by catgut ligatures, using no drainage; dress the wound antiseptically, with slight compression.

It is of great importance to maintain the uterus in good position during convalescence, using a Hodge pessary to insure anteversion. The pessary should be retained some months after the operation, or by antiseptic tampons frequently renewed.

Permit me to emphasize the danger of operating after long-

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continued hæmorrhage, as very rapid degeneration of the heart-muscles is not infrequent, and the operative treatment of uterine deviations requires the most careful individualization.

Fatal cases have been reported following this simple but greatly complicated operation.

Harrington collected 140 cases, with three deaths from twenty-one operations.

The operation is more generalized and is practiced everywhere with variable success, which appears to depend entirely upon the experience of the operator and the degree of clearness with which the indications are appreciated. The operation has given excellent and permanent results in downward and backward deviations of the uterus, which were previously fixed by adhesions in retro-flexion, mobilized by treatment but unable to preserve the position itself or by a pessary.

As the results of experience with this operation and its many modifications, I think it useless for procidentia, unless accompanied by complementary operations on the vagina and perinæum. It is not advisable to operate while complicated adhesions or a high degree of metritis exists, except where they can be broken by gentle manipulation.

It is warmly recommended for uterine flexion in virgins, in whom other operations, such as vaginal fixations, is impracticable on account of a narrow vagina.

The uterus, usually small, is easily retained in position by the shortened ligaments.

The general value of the operation is in old cases of retroversion and flexion, especially when accompanied by prolapse of the ovaries, so that the wearing of a pessary is not practicable. When this operation has been contraindicated or insufficient, other methods are to be employed.

The greater number of our gynæcologists who have had practiced experience with Alexander's operation have declared in its favor, and it will undoubtedly continue to be done successfully in properly-selected cases, and in the hands of experienced surgeons, including the accessary operations for lessening the weight of the uterus, narrowing the vaginal walls, and repairing the torn perinæum.

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CASE III.—Miss R., 27 years of age, suffered from puberty; menstruation painful and irregular; anticipating; character of the flow normal; when 15 received an injury to small of back by being thrown from a horse, causing, no doubt, the retro-deviation discovered on examination. Uterus was easily replaced but unable to retain in position, using all forms of pessaries. Failing to give her relief with palliative treatment, advised Alexander's operation, for which I readily gained her consent.

Operated April 30, 1896. Had no difficulty in finding the ligament on right side, but the left one gave me considerable trouble, owing to the smallness of it. Proceeded to fix the uterus as described under the head of Alexander's operation, to find all terminate favorably at the end of two weeks. She made a good recovery, and reports herself a new and well girl. It is now four months since the operation, and the uterus maintains a good position.

Colpo-Hysteropexy and Vaginal Hysteropexy.—Ammessat was the first to attempt the antero-vaginal fixation of the uterus; after reducing it to a normal position, applied the hot iron and cauterized the side opposite to the displacement to produce a cicatricial band, to which the organ was restored. With the same object in view (Sims), caught up a transverse fold of the vagina, sutured it to shorten one or the other walls of the canal.

Freund suggested the injection of alcohol in the neighborhood of the utero-sacral ligaments, and into the retro-cervical cellular tissues, for the purpose of contracting these ligaments to produce a cure.

In spite of reported successes, this adventurous procedure does not seem to be worthy of recommendation.

The different operations have their different methods. Lengthening the anterior vaginal wall by a transverse incision, then suturing it longitudinally, also consolidating the cervix with the posterior wall of the vagina, uniting the anterior vaginal wall on the anterior surface of the cervix; retro-cervical colporrhaphy.

Fixing the fundus of the uterus to the vesico-uterine cul-de-sac by passing a strongly-curved needle, armed with a double

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thread, through the cervix of the dilated uterus, piercing the vaginal fundus and vaginal pouch between the bladder, tying the suture, producing a complete anteflexion. Remove the suture on the tenth or fourteenth day, at which time the anteflexion disappears.

It has been suggested by some authorities to incise the cervix, then to open the anterior vaginal pouch and separate the bladder from the uterus, excising the anterior wall of the uterus the distance of one inch and suturing the wound. Others have adopted the transverse section of the anterior cul-de-sac of the vagina and peritonæum behind the bladder, suturing the uterine body to the vagina, uniting the vaginal wall on a vertical line to elongate the anterior wall of the canal and permit the cervix to return backward.

Numerous other methods have been suggested similar to the ones described, but I shall refrain from taking the time or space to mention them. (Ammessat, Biford, Cousty, Richelot, Sr., Doleris, Sims, Freund, Schultz, Nicoletis, Van Rabenan, Schucking.)

Antero-Vaginal Fixation of the Uterus.—This method of fixation, as practised and recommended by Mackenrodt, suitable only for movable or easily movable retro or downward deviations of the uterus. It consists of a transverse incision in the anterior vaginal wall, slightly curved in direction of the column, cutting vertically in a right angle from the meatus urinarius in the median line toward the cervix until reaching the first curved incision. The flaps in this way dissected are to be taken off the bladder, then the bladder is to be loosened with a blunt instrument from the column up to the os internum. Transfixing the uterus through the incision by a tenaculum and sound in the organ, carry it up close against the anterior vaginal wall. Now join both flaps with the uterus by one seam (using chromicised catgut as a ligature), which has to be made a little above the os internum, through the unopened peritonæum and the anterior wall of the uterus; but this seam shall not go through the vaginal mucosa. Finally, close the transverse circular incision.

Pretty nearly the identical procedure has been recommended

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by Zweifel, differing only by the one point, that the latter uses a different stitch—the interrupted suture (four to five in number) and Schucking's needle.

In regard to the surgical treatment of retro-deviations there is the greatest diversity of opinions.

A review of the literature of the last eight years bearing upon the subject of anterior-vaginal fixation is most interesting.

This method was thoroughly discussed by the Gynæcological and Obstetrical Society of Berlin, January 24, 1896, which arrived at the following conclusion:

Dr. Flaischlen expressed his opinion that the views of Strassman and Graefe are receiving more supporters, that vaginal fixation of the uterus should not be performed on women capable of conceiving, if it can be avoided. He mentioned twenty-two cases of vaginal fixation, in four of which there were severe complications in labor; also the fact that pregnancy is liable to loosen the adhesions, and the uterus to become retroflected afterwards. Professor Olshausen considered vaginal fixation a valuable addition in gynæcological surgery. The tendency was to overdo it, both in the indications and in its technique. He would restrict the indications to perfectly movable uteri without any disease of the adnexa, and even here it should be modified by the severity of the complaints and the age of the patient. The technique is overdone when the entire anterior wall is fixed. He introduces the upper stitch only one or two centimeters above the internal os without opening the peritoneal cavity. He uses a buried silk-worm suture and has no trouble with it.

Dr. A. Martin thinks that the indication for the operation in uncomplicated cases of retroflexions is very rare, as a vaginal pessary will usually relieve the symptoms. He finds it a necessary supplementary operation to anterior colpotomy for prolapse operations. He uses absorbable suture material, and fixes the uterus two or three centimeters below the fundus, but he does not hesitate to fix the fundus if myomas have been removed from this portion of the uterus with more or less loss of substance.

I am firmly of the opinion that the vaginal fixation is better

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borne than the abdominal operation, and the former might be attempted in an anæmic patient when the latter could not be sanctioned.

CASE IV.—Mrs. J., aged 29, came to my office July 8, 1895, to consult me as to her condition; she was habitually constipated, and complained mostly of pain in small of back and severe headache at times. Was married when twenty; had one child five years of age; no miscarriage. On making a thorough examination, found a lacerated cervix, sub-involution, chronic ovaritis and a retro-deviated uterus. Two months later, finding no relief, after a persistent line of palliative treatment, advised the radical vaginal fixation.

October 25, 1895. Having patient properly prepared, proceeded to operate, completing the fixation in twenty minutes, leaving her bed in a fortnight to make a rapid and permanent recovery. Ten months since the operation, and she reports herself entirely cured.

Examination shows the uterus to be firmly fixed anteriorly, producing no inconvenience whatever.

CASE V.—Mrs. T., æt. 31. Operated June 10, 1895. I reported this case in full under the head of "Three Months' Work in Surgery," in the State TRANSACTIONS of 1895. Eight months after her rapid and uneventful recovery she became pregnant. I called on her one week ago to find her in the very best of health and progressing nicely in her delicate condition. (Mackenrodt's method.)

Having presented the different methods of operating for fixation of the deviated uterus, which merits the confidence of the medical profession, I beg to offer this little, terse, impartial review of the work that has been done with them by eminent specialists of this country and Europe. It is intended, however, that this paper shall serve merely as a preliminary review, with the hope that everyone of our gynæcologists will favor us with a contribution to the above work in the near and progressive future.

Making the allowances for exaggerations natural enough in discoveries and operations to which such progress has been attributed, it cannot be devoid of usefulness, and it should take its place in the great field of gynæcological surgery.

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AS TO THE WHEEL.

ANNA C. CLARKE, M.D., SCRANTON, PA.

DURING the past year so large a number of my patrons have sought advice regarding the use of the wheel that, thinking my experience has not been different from other physicians, I have been led to present this paper to the Society, hoping to bring out a general discussion, and thus help to formulate some general principles governing its use. That man has for many centuries conceived the idea of propelling himself by mechanical means other than by the aid of animals is evident, and that it was accomplished is altogether possible, yet the records are so imperfect that the student finds slight clue in tracing manual locomotion to its birth. The first evidence that such a means existed is found in the most unlikely of sources—a stained-glass window, bearing the date 1642, in a country church at Stoke Pogis, four miles from Windsor. The church-yard is famous as being the scene of Gray's "Elegy," and contains the remains of the poet.

To trace the history of the wheel from this early date through all of its various modifications would be useless; sufficient is it that out of the many crude inventions has come the high-grade wheel of to-day. The first woman's wheel—the "Ladies' Ariel," with lever pedals on the left side and forkless backbone—was introduced in 1872. Now we have the Safety, with but little difference between those for men and women.

One can scarcely realize what an important factor the bicycle has become until we are confronted with the fact that there were over 2,500,000 used during 1895 in the United States, and that it is estimated a million more were sold during the past summer. This represents a manufacturing investment of over $75,000,000. It is evident that a means of locomotion in so general use, the manufacture of which is on such a stable foundation, is sure to remain, and must necessarily have a great influence on the physical, mental and moral nature of the people.

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Physicians are daily asked for their opinion as to its use. What shall it be?

By common consent it is conceded to be an excellent exercise for men, but when women are taken into the question some of our ablest men condemn it *in toto*. However, the majority are in favor of its proper use. The wheel as a means of physical development is as well suited to one sex as to the other; if there is any difference, the advantage is in favor of the woman. She needs all-round physical development. A certain set of muscles are exercised constantly in the dispatch of the home duties, and the wheel seems to have come just in time to save the others from atrophy, for there is not a muscle which is not called into action in its use. Balance must be maintained; this cannot be accomplished without the complementary action of the muscles of the limbs. The handles, while they should never be held tightly, bring into play the muscles of the chest and arms. Many women, especially those in the higher walks of life, have hitherto found it almost impossible to take vigorous out-door exercise. They *will ride* the wheel, and it cannot be done without bringing into use all the muscular powers.

Over-exercise on the wheel is no worse than over-exercise in any other manner.

I doubt if women are any more injudicious in its use than men, and it certainly has been of a vast amount of service to them in affording an out-of-door exercise at once healthful and fascinating.

The period of relaxation in any set of muscles somewhat exceeds that of contraction, giving a vast amount of exercise without weariness. When a woman is beginning to ride, I advise short lessons, with frequent rests between the attempts. Ten minutes is long enough to remain in the saddle, however strong the assistant may be. The wheel should be low-geared, the saddle comfortable and the position upright.

There is no other form of exercise which brings so many of the muscles into play, therefore they demand freedom of action; hence dress becomes an important factor. It should be such as to combine freedom of movements with lightness of weight and warmth, and close-enough fitting not to hang on the per-

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son, and yet avoid pressing upon any part of the body. An ideal garment to be worn next the body is the light-weight wool combination suit.

The outer garments should be neat and plain, whatever the mode, and while the bloomers are perhaps the most convenient, the divided skirt or short over-equestrian trousers, while nearly as convenient, have the advantage of being less conspicuous. The craze for cycling has brought about great physical changes. Through a demand for greater freedom of movement and respiration, the waist and chest measurements have increased from three to five inches. With better-developed muscles the corset has in many cases been found unnecessary, and has been abandoned. With increased muscular action comes deeper respiratory movements, stronger heart-beats and better circulation. All persons with organic heart-disease should be forbidden to use the wheel, lest they be led to overtax that organ and cause instant death. It is my custom to caution against riding steep grades, or at such a distance or speed as to produce shortness of breath or a weak feeling in the chest. I believe that in the early stages of consumption, and as a preventive against that disease, the wheel is as useful as the horse.

Great care should be exercised in the selection of a saddle. There are many on the market which are an abomination, and have caused untold trouble. The saddle should be wide enough to give ample support to the ischia, and firm enough to give one a good purchase on it; the hame-shoot and the centre of the saddle open or so constructed as to avoid all pressure on the soft parts, and the whole supported on a coil spring. It should be so adjusted as to be parallel to the antero-posterior diameter of the pelvis, and just high enough for the ball of the foot to rest on the pedal when the leg is straight down. A saddle in this position can never cause irritation to the vesico-vaginal tissue. On the other hand, the exercise is most beneficial to the pelvic organs, causing an increased circulation—strengthening the uterine ligaments by the kneading of the abdomen; by the increased leg-actions the blood is drawn from the pelvis.

It prevents or relieves constipation, thus avoiding pressure from that cause upon the ovaries and uterus.

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I have found it most useful as a remedial measure in menorrhagia and metrorrhagia when due to congestion. A patient reported at this writing, who has been suffering from menorrhage for three years, had had the indicated remedy and the usual rest treatment without results. Six months ago she began riding the wheel, and has decreased duration of period from twelve to four days, while the amount of flow is about normal.

The wheel is useful in neuralgic dysmenorrhœa, acting as a general as well as local nerve tonic.

Displacements of long standing do not seem to be aggravated. The wheel is counter-indicated by all acute or recent inflammations and diseases calling for operative interference. While some ride the wheel without inconvenience at the menstrual period, yet I do not think it advisable to do so. There has recently appeared a number of articles in our medical journals condemning the wheel, because it is thought to produce a so-called "bicycle eroticism." Should such a condition result from riding, it would be from a saddle so uncomfortable as to cause it to be at once rejected, and I doubt if sexuality is ever increased. The subject is obviously one difficult to investigate. However, I am told by a number of intelligent riders, those who were interested in ascertaining the truth, that they noticed no change in that function.

Rectal diseases when they already exist seem to be aggravated by the wheel, which I believe is often due to improper saddles. Hæmorrhoids when due to constipation are benefited, and often entirely cured.

With a stronger circulation, better developed muscles, women of this generation cannot help but be better fitted for gestation; labor will be shorter and easier, the recuperative powers stronger. What effect the wheel will have upon the formation of the pelvis, when children ride so constantly during the formative period, remains to be demonstrated by the next generation. The wheel would be one of the greatest benefits to women if its good results were confined to the muscular and circulatory systems alone—but it is one of the best of nerve tonics. It affords an outlet to the pent-up nerve force that nothing else

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gives. All conventionality is lost. A women tired and nervous from the constant strain of home cares springs into the saddle and takes a run for half an hour, to return refreshed in body and mind. It is an excellent remedy for neurasthemia. Women have long been looking for something that will break the treadmill of life, and it has come, bringing with it healthier bodies, clearer minds and happier homes.

The wheel has an influence far reaching, and it devolves upon the physician to so control it as to reap the best results.

DISCUSSION.

T. H. CARMICHAEL, M.D.: As a rider I heartily endorse the paper just read, especially that part in reference to the kind of saddle to be used. I think that this Society should condemn all saddles constructed on the hammock principle, viz., those in which a piece of leather is stretched over a frame from a point in front to one in the back part. These bring the weight of the body on the soft parts, and have caused many troubles, especially in long rides. The proper saddle has a firm point of support on both sides for the ischial tuberosities.

In regard to the benefit to women there can be no doubt where the wheel is used in moderation, and riding is avoided during the period of congestion of the pelvic organs.

BUSHROD W. JAMES, M.D.: In regard to this subject I have noticed much benefit to women in the use of the wheel, inasmuch as it gives them an incentive to go out every clear day, if they can so do, and thus get healthy exercise; while, otherwise, without owning a wheel, many would stay in the house probably for a week or more, which is greatly detrimental to their health. When the question came up in our Society about a year ago I condemned at that time the excessive long journey and rapid riding of the wheel. In my experience rapid riding is apt to produce heart-weakness, and possibly heart-failure, in feeble persons, and probably instant death, as I have known. Riders are not limited to those who have heart-disease, it is true, but rapid riding, racing, century-riding, a spin of many miles in twenty-four hours, have all unquestionably produced deaths from the excessive fatigue and over-exer-

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tion of the muscular and nervous system thus occasioned. This Society should have little or nothing to do with recommending this or that mechanical arrangement or seat, if comfortable and not injurious; the attachments are not to blame; the fault lies in the excessive riding. The members ought to give their personal attention and advice to the individuals using the wheel; we certainly agree that there is too much long riding, too much spurting and "scorching." I fully approve of the judicious use of wheels by males and females, but there should be laws adopted for their use on the public highways. No riders should be allowed on the streets with a bicycle unless they are proficient in its use. In Vienna there is a law which requires every person to give individual evidence of proficiency before he or she is allowed on the streets, and this evidence is attested by the issuance of a certificate stating that fact. To show the dangers of careless and inefficient riding, I remember seeing, on my way home last fall, an apparently skilful rider come into collision with the back wheel of my vehicle, throwing him forcibly off and damaging his wheel. A few days after this I came across another case of a young woman riding ahead of my carriage aiming to pass a team, when the horse shied towards her, compelling her to make an abrupt turn, throwing her off headlong and breaking her bicycle. Recently I saw a lady thrown in the Park in crossing a rut in the road. These accidents are occurring in our large cities and on our country roads all the time. There should be some regulation by which persons not sufficiently familiar with the machine could be kept from our public highways. I like the method of having people registered and giving a certificate that they can properly use the wheel. The teaching of people to ride in the streets is wrong, on account of the dangers incurred by passing vehicles. I fully approve of the use of the bicycle under proper circumstances and restrictions.

Isaac Crowther, M.D.: In regard to the use of the wheel, especially by women, I agree most heartily with the author of the paper. It should be prescribed by the physician as he prescribes any remedy which is indicated by the conditions of the case, so as to do the most good; for instance, the weight, height of frame, height of saddle, length of crank-arm, should all be

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taken into consideration, as well as the make of the wheel. If she live in the country where there are high hills and bad roads, you do not want high-geared wheels, not over fifty-six or fifty-eight, and then the crank-arm ought to be of sufficient length to give good leverage, so that she can have the wheel well under control. It must be adapted to the woman to meet her needs. There are some diseases that the wheel will benefit; there are other diseases that lie on the borderland of discussion, and it is not for me to determine whether the wheel here is absolutely beneficial or not. It is said by most authorities that epileptics should not ride the wheel. I have in my practice a young woman, coming from an epileptic family, who has been riding a wheel for over a year with marked benefit to herself mentally and physically. Previously she had had habitual convulsions; she has never had a fit on the wheel, but has had, however, two or three fits in twenty-four hours, day or night. It seems as though the effort to concentrate her mind upon the control of the wheel and the benefits of out-door exercise have enabled her to overcome these fits to some extent, given her more self-control and confidence, and improved her general health. She never rides fast nor alone.

Z. T. MILLER, M.D.: I believe there is no remedy or hygienic benefit that reaches the disease called hysteria, spinal irritation, etc., as quickly as the proper use of the wheel. I know a school-teacher who took to the wheel who was troubled by the above complaint. She now rides fifteen miles a day with marked benefit, although she is not entirely well, and I do not know but that this very attention to the wheel takes her mind away from herself.

It is said that the wheel is a Chinese invention. I believe Li Hung Chang said this in New York while on his visit there. He says the bicycle was used in China years before it was ever used in this country. The use of the wheel, I believe, is overdone. We have hills to go up and difficulties to overcome in its use as in other branches of moral and physical improvements. I read a paper a great many years ago in which I stated that the wheel would bring about a change in locomotion —that the "horse must go." I still believe this.

JOSEPH E. JONES, M.D.: During the past year my attention

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has been called to one thing in connection with the wheel, and I want to ask others whether they have noticed the same thing? A number of cases of amennorhœa or the stoppage in the catamenia in young girls who have been riding a wheel have come to my attention, some requiring medical attention. They attributed the delay to the wheel, and yet they were not excessive riders, having the best of wheels with the most approved saddles; there were no other nervous symptoms attending it. Have others observed the same trouble as being consequent on the use of the bicycle?

JOHN E. JAMES, M.D.: I have no objection to the use of the wheel, but I do object to its abuse. There ought to be some good advice given by physicians to their patients on this subject. In regard to the remarks made by Dr. Jones, very often taking our young ladies from the city and sending them to the seashore or transporting them across the water will cause them to miss their periods in the same manner. I have nothing to say against the proper use of the bicycle. I believe it to be good exercise, and far better than horseback riding for most women. I read in the paper the other day of a man riding on a trolley car who asked the motorman, "How often do you kill a man on this line?" and he replied, "Never, but once." So, in regard to the wheel, its proper use should not be condemned. It has its restrictions and risks, from which we are not exempt in any department of transportation in the country.

WILLIAM W. VAN BAUN, M.D.: I favor the use of the bicycle by women and girls within districts safe for wheeling, and object to its use by anyone in crowded streets. The wheel is a thing of pleasure, and has contributed more to the health and happiness of both young and old of both sexes than any other thing at command. It calls into play nearly all the muscles of the body, and adds to the woman, as to the man, grace, quickness of motion, improved balancing power and rapidity of decision, with constantly-increasing aptitude of correct judgment in critical situations. I insist with all my patients, men, women and children, that they must avoid fatiguing ascents, over-long rides, and the temptations of fast riding; with the final advice to keep their mouths shut in riding, and on finding it in-

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tuitively coming open to dismount and rest. With those not in good health specific directions are needed to suit the individual case. As the time at the disposal of the bureau is growing short, I will ask Dr. Clarke to close the discussion.

ANNA C. CLARKE, M.D.: There have been some cases of pelvic inflammation in Scranton which resulted from riding the wheel, probably because the riders allowed themselves to ride too far before they became accustomed to the action of the wheel. In Scranton there are very hilly streets, and I believe there is only one block safe for beginners to learn upon, from which carriages thoughtfully stay off. I recall the case of a young girl who, for her first lesson, was put upon a wheel by a strong assistant, who ran with her about one or one and a half hours. The next day she rode to a town fifteen miles distant over an unpaved street, making a ride of thirty miles. Two months afterwards she was still in bed with an inflammation involving nearly all of the pelvic viscera. She is seriously ill.

As to nervous diseases, there is a case of a young girl who had never menstruated up to the age of eighteen years, in conjunction with which there was hereditary insanity. Upon the advice of Dr. Ware she began using the wheel, and after a short time she began to menstruate, the symptoms of insanity disappeared, and she has continued to improve for the last six months.

THE DEVELOPMENT OF ACUTE SALPINGITIS IN YOUNG WOMEN.

B. F. BETTS, M.D., PHILADELPHIA.

WHILST it is generally admitted that a gonorrhœal infection may furnish the elements necessary for the development of acute salpingitis in young women, we know from clinical observation, as well as from bacteriological research, that there are many infectious micro-organisms capable of inducing this disease beside the gonococci, and that in order to be successful in treatment we must appreciate the importance of an early

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recognition of the conditions which favor the development and multiplication of these infectious principles within the cavity of the uterus and in the Fallopian tubes.

At parturition we have constantly in mind the danger from an infection of the reproductive channel, whilst the tissues are vulnerable and absorption is readily effected through the open-mouthed lymphatics, the distended veins and the rents in the mucous membrane. In gynæcological practice we are always confronted with the fact that bacteriological agents common to the inflammatory condition in other parts of the body are mostly present in the fornices of the vagina and crypts of the cervical canal, ready to pass into the cavity of the uterus from the introduction of the sound or other instrument, and from thence into the Fallopian appendages from continuity of structure.

Even without such an instrumental agency the cavity of the uterus may become invaded by germs which only await a local congestion or a certain constitutional state that furnishes a suitable culture fluid, to become so virulent as to induce an acute septic infection of the endometrium, followed possibly by salpingitis and ovaritis from an extension of the infection along the mucous channels.

It is in this way that the infection mostly spreads in those who have never borne children, and whilst it is to be presumed that it occurs more readily in those conditions of health in which the constitutional state induces in some manner a defective tissue metamorphosis, there can be no doubt that purely local changes in tissue metabolism, vaguely manifested to us, may be of such a character as to favor the growth and multiplication of infectious agents.

The local conditions which seem to favor infection in young unmarried women are often induced by displacements of the pelvic organs with such an hyperæmia and hypersecretion as will furnish a suitable culture-fluid for pathogenic organisms. This is especially the case when a flexion at the cervix or a congenital stenosis of the canal tends to impound the liquid secretions within the uterine cavity and increase the vulnerability of the mucous membrane.

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When there is a displacement of the uterus that causes the channel to become tortuous or the outlet to assume an unfavorable position for drainage, the menses will be imperfectly discharged, so that the uterine cavity will always contain the residue as a culture-fluid, from which infection is liable to occur. The hyperæmia of the tissues is followed by hyperplasia or increase in size and weight, so that we have added to the symptoms already present painful menstruation, backache, pelvic tenesmus and rectal and vesical irritation.

Similar changes take place within the tubes: the tissues become hyperæmic, the secretions are increased in quantity and the canals become closed at certain points or tortuous from kinking, so that the fluids collect and distend the tubal structures, and as a consequence pain is induced and sensitiveness becomes an ever-present symptom.

Eventually the ovary may feel the effects of the same disturbing influences and become larger and heavier, so that an effort at lifting or straining, or particularly a sudden jar or fall, will cause it to descend and drag the tube with it toward the cul-de-sac of Douglass, after which the hyperæmic and possibly infected peritoneum may throw out an exudate that will envelop the ovary, tube and fimbria, constituting the veritable tubo-ovarian mass, within the centre of which an abscess may form from the presence of infectious germs at the ampulla or abdominal end of the tube.

From my record books I am able to trace many cases of this kind to a displacement caused by a serious fall or a sudden jar, as from a railroad accident, as well as to the habitual use of the corset, or neglect respecting the evacuation of the rectum and bladder at suitable intervals. As but little attention is paid to the earliest manifestations of salpingitis in young women, the damage is often too serious for medicine to cope with alone when the case is diagnosed by the physician. It therefore seems necessary to emphasize the fact that injuries from the causes mentioned above should claim our prompt attention, and that in all such cases it is necessary to secure the most efficient drainage from the uterine cavity by efforts to straighten the uterine canal, and in every case after a serious fall or simi-

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lar injury an examination should be made by a reliable physician in order to correct displacements and determine the condition of the pelvic organs.

If deep-seated pain is induced by lifting the uterus upon the point of the examining finger it will be of considerable diagnostic significance, for it indicates a degree of hyperæmia of the uterus or tubes that marks the advent of serious pelvic disease. Of course the deep-seated tenderness is to be distinguished from mere vaginal sensitiveness which is almost always met with in this class of patients. It will be noted, therefore, that we have several reasons for selecting the rectal method of exploration, for we not only eliminate this source of error, but we can reach to a higher point in the pelvis, and, above all, we avoid inflicting the moral shock upon the sensitive nervous organization of the young woman that comes from the reckless choice of the vaginal route in such cases.

If the rectal method does not enable us to make a satisfactory diagnosis or secure the facilities for a replacement, an anæsthetic should be administered before proceeding with the subsequent vaginal examination, but in all such cases it is best to make the initial rectal exploration first, without an anæsthetic, in order to determine the amount of uterine and ovarian mobility and sensitiveness present. If the displacement is of long standing, and the uterus is large and not freely movable, the best judgment will be required to determine the line of treatment best adapted to the case, as the attempt to effect a replacement under such circumstances will be likely to inflict additional suffering by increasing the inflammation previously developed, and we may well consider the advisability of postural treatment with general massage and internal medication, or the necessity for an operation for the removal of the damaged organs by an abdominal section.

If the case is seen early, replacement can usually be effected without difficulty, and we need only to guard the patient against a recurrence of the malposition. If there is considerable tenderness met with, as referred to above, frequent replacements do more harm than good, and postural treatment should be relied upon exclusively, with suitable medication, of course, ac-

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cording to the indications as they arise. Pessaries are not required in acute cases, especially when there is sensitiveness in the posterior and lateral portions of the pelvis. After postural treatment in these cases this sensitiveness will diminish, if the tubes are not seriously affected, and exercise should be gradually resumed, with the clothing properly adjusted, so as not to constrict the waist nor interfere with muscular movements. When the tubes are permanently diseased we will experience more trouble in securing good results without an operation.

In cases of long-standing prolapsus of the first degree, without retroversion, the development of an increasing amount of dysmenorrhœa, with pelvic pain during the intermenstrual period and uterine sensitiveness, point to some stenosis of the canal, due, perhaps, to an acquired anteflexion of the cervix.

This stenosis may be overcome by divulsion under ether and the application of a suitable pessary to elevate the uterus and keep it from pressing the cervix against the pelvic floor. When there is a congenital anteflexion with stenosis it may be necessary to straighten the canal by an incision through the posterior lip of the cervix up to the point of constriction, so that the cut surfaces may be stitched to the denuded vaginal wall above in order to keep the cervix back and the canal straight, so that the discharges can pass without obstruction.

The treatment of married females suffering from a displacement caused by a fall or similar accident is usually attended with less trouble, and it is seldom necessary to administer an anæsthetic for the initial examination. If more than the usual difficulty is experienced in effecting a replacement *per vaginam*, the patient may be directed to assume the knee-chest position for that purpose. This position can be utilized to the best advantage by having the patient kneel upon one chair or stool whilst each forearm is placed upon another stool or chaif so that the three supports are arranged in the form of a triangle about two feet apart. In this manner the pelvis is elevated to the proper height for the operator, and by raising or lowering the shoulders and trunk, moving them forward or backward as directed by the operator, every facility is secured for replacement that is possible. The position is much less irksome to

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the patient when the body is supported in this manner than when it is on a bed or table with the head turned sidewise at an uncomfortable angle with the neck, and it is much more convenient for the operator.

The treatment after replacement is, of course, about the same as that outlined above for unmarried women.

In a series of 884 cases examined in private and consultation practice, twenty patients attributed their pelvic disorders to a fall of some kind, and are classed together in the following tabulated list.

Many other patients might have been appropriately assigned to the same category who were suffering from the effects of direct concussion, over-lifting, pushing, jumping, etc., but the addition would make the list too lengthy.

All the accident cases due to a fall, as tabulated on the following pages, suffered from some form of uterine displacement and from some variety of tubal disease. Some may have had the displacement, and even the tubal complication in its incipiency, without recognizing it before the reception of the injury, but in all of the cases the accident seemed to precipitate the more serious manifestations of the trouble.

Of the twenty cases reported, nine were married and eleven were single at the time they came under observation, and it is a significant fact that all the married women remained sterile after the injury.

All the cases had similar subjective symptoms, amongst which pelvic pain, backache, headache, dysmenorrhœa and nervous phenomena predominated. The cases cured were those seen soon after the fall or those operated, but the records of the cases seen only in consultation are incomplete in this respect, as they were not heard from after a replacement was effected at the time of the examination.

The degree of anteflexion met with in this list was in excess of the normal for nullipara and evidently contributed to the stenosis, dysmenorrhœa and subsequent salpingitis.

The position assumed is that the early treatment of patients who have sustained an injury which is likely to produce some displacement of the pelvic organs will often prevent the develop-

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Case Number.	Married or Single.	Age.	Accident.	Uterus.	Ovaries and Tubes.	Menstrual Pain.	Treatment.	Results.	Remarks.
1009	S.	30	Fall from swing.	Prolapsed and adherent.	Ovaries and tubes bound down by adhesive ovarian hæmatoma.	Very intense.	Medical and postural for long time. Cœliotomy, suspension of uterus & removal of appendages.	Cured.	
1011	M.	35	Fall into a low chair.	Prolapsed and retroverted.	Salpingitis and ovaritis.	Not severe.	For diagnosis only.	Not known.	Sterile since accident.
1051	S.	32	Fall from a carriage. In bed 16 wks. Three years later came under observation.	Prolapsed and retroverted.	Salpingitis and pelvic peritonitis, with firm adhesions all through pelvis.	Severe.	Not operable, medical.	Slight improvement.	
1154	M.	23	Fall down stairs. Fall from hammock.	Prolapsed; fundus anteflexed.	Salpingitis. Abscess in l. ovary.	Severe before flow, not during.	For diagnosis only.	Not known.	Sterile.
1433	S.	25	Fall down cellar steps.	Prolapsed.	Salpingitis.	Severe.	Replacement with postural & medicinal.	Cured.	
1543	M.	28	Fall into seat, 12 yrs. ago.	Prolapsed anteflexed fundus.	Salpingitis and ovaritis.	Severe for 1 week before. Intense headache 1st day of flow.	For diagnosis only.	Not known.	Sterile.
1609	S.	25	Fall down stairs, 3mos. ago.	Prolapsed, very sensitive.	Tubes and ovaries sensitive.	No pain until after fall.	For diagnosis only.	Not known.	
1666	S.	26	Fall from hammock, 6 yrs. ago.	Retroflexion.	Salpingitis and ovaritis.	Severe.	Postural, medicinal, curettage, replacement.	No relief.	Refused coeliotomy.
1708	M.	31	Fall, 17 years ago.	Prolapsed.	Salpingitis and ovaritis.	Very severe.	Medicinal.	Improved.	Sterile.
1718	S.	21	Fall, recent.	Prolapsed and retroverted.	Tubes and ovaries displaced.	Severe for the 1st day.	Replaced after etherization.	Improved.	
1731	M.	24	Fall, 1 yr. ago.	Prolapsed anteflexed.	Salpingitis, right ovaritis.	Pelvic tenesmus, backache.	For diagnosis.	Not known.	Sterile.
1732	S.	27	Fall down stairs, 6mos. ago.	Prolapsed cervicitis.	Salpingitis.	Severe 3 days.	Rectal replacement, medicinal.	Cured.	

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Case Number.	Married or Single.	Age.	Accident.	Uterus.	Ovaries and Tubes.	Menstrual Pain.	Treatment.	Results.	Remarks.
1737	S.	37	Fall on ice.	Prolapsed fundus anteflexed.	R. tube inflamed, r. ovary enlarged, l. tube and ovary adherent.	Very severe before and during menses.	Cœliotomy, r. hæmatoma, intestinal adhesions, salpingitis removed.	Cured.	
1758	S.	22	Fall onto the feet.	Retroversion with prolapsus; endometritis.	Salpingitis, ovaritis.	Not severe.	Cœliotomy, suspended uterus, removed appendages.	Cured.	
1766	S.	23	Fall astride top of chair, 7 years ago.	Prolapsus with anteflexion of fundus and cervix.	Ovaritis, salpingitis.	Very severe.	Operation declined.	Not known.	
1802	M. 2 yrs.	41	Fall from bridge, six years ago.	Retroversion with prolapsus.	Suppurating tubes and ovaries.	Severe formerly.	Medicinal.	Improved.	Sterile.
1803	M. 3 yrs.	25	Fall from tree, 11 yrs. ago.	Prolapsed.	Salpingitis and ovaritis, ovaries prolapsed and adherent.	Very severe.	Cœliotomy, removed appendages.	Cured.	Sterile.
1816	M. 11 yrs.	39	Fall down stairs, 19 years ago.	Anteflexed hyperplastic.	Left tubo-ovarian mass. R. salpingitis.	Severe.	Medicinal.	Not improved.	Sterile. Refused cœliotomy.
1827	S.	23	Fall out of bed.	Prolapsed.	Right tubo-ovarian inflammation.	Not severe.	Replaced and medicinal.	Improved.	
1829	M. 3 yrs.	23	Fall down stairs.	Prolapsed, retroverted	Right tube painful. Left, ovaritis.	Not severe.	Medicinal.	Improved.	Sterile.

ment of serious pelvic disease, with subsequent suffering and possible sterility.

DISCUSSION.

THEODORE J. GRAMM, M.D.: I am delighted with this paper. I think it opens a large field for thought. It is true, as the doctor stated, that the larger proportion of cases of salpingitis and tubo-ovarian abscess are due to gonorrhœa of a mixed in-

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fection; and yet these are not all the cases wherein salpingitis occurs. Gynæcologists will tell you that there are some cases that are not traceable to gonorrhœa. I know of such a case in which there was no direct infection with gonorrhœa, which case presented conditions due to imperfect drainage from the tubes and uterine cavity. I do not consider that the examination for this condition is made as frequently as it should be. To discover any mass in the pelvis to my satisfaction, I always insist upon complete relaxation of the abdomen. In many cases you will find the uterus displaced. The uterus in the cases I cite were markedly displaced, one retroflexed and the other retroverted. These cases also exhibited a prolapsed ovary and the presence of infection in the Fallopian tube. In the treatment of these cases it is not always necessary to subject them to abdominal operation. I insisted upon an examination under ether and thorough relaxation of the parts was obtained and the condition was demonstrated. These cases were treated by the use of a pessary. I preferred the use of a pessary in these cases, inasmuch as we have there a convenient means for keeping the uterus in place. It is quite true that the majority of these cases do not come to us early enough. They are treated for ovaritis and dysmenorrhœa or for some vague condition which is not definitely demonstrated. If drainage can be secured and the uterus can be held in position by a pessary the uterus will take care of itself as far as infection by microorganisms is concerned.

JOHN C. MORGAN, M.D.; I was interested in the point made by the author of the paper in reference to the immobility of the uterus and its replacement. My attention was called many years ago to remarks by Dr. Constantine Hering, in which he spoke of the spiral construction of the internal organs and the general characteristics as applied to displacements, which I think is of great importance. Dr. Hering undertook to say that all of the internal organs were arranged in a spiral direction. He proposed to come into my anatomical lecture-room and make a demonstration of this, but for some reason he never did it. Now, I have much faith in his theory as applied to cases such as Dr. Betts has alluded to; where the uterus is

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immobile, where it is retroverted, and where all efforts do not bring it into its proper position. In such cases I think the application of Dr Hering's views as to the spiral character of the internal organs is exceedingly important, and I have eliminated considerable difficulty that I formerly experienced in replacing the uterus by simply making application of this rule. If we will trace the direction that the uterus takes in marked retroversion, we will have a striking illustration of his views. As a matter of fact, the uterus is not retroverted directly backwards; that is a notion which needs universal correction. Almost everybody believes that the uterus goes backward in a straight line, and yet it is never so. It follows the normal spiral direction of its anatomical arrangement, which is illustrated by the shape of the bowels. We know of their spiral direction, and if we consider the phenomena and carefully examine the patient, we will find that this course is followed in the displacement. There is no exception. When the uterus follows this spiral direction to the hollow of the sacrum, it first tilts to the left; that is the first stage of retroversion. Then it makes a full left lateral version, and the next step is a backward movement of the fundus. In the complete third stage it makes a right-handed movement, at the same time that it goes into the hollow of the sacrum. All this follows the direction of the spiral axis of the uterus in the pelvis, and when properly understood will aid one greatly in modes of treatment for replacement. How are we to make an application of this law? When we make an effort and find the uterus immobile, we attempt forcibly to push it forward, and every time we take away the pressure the displacement returns. Now, by moving the fundus to the left and by making it take a direction opposite to that when it became displaced, that is upwards, forwards, and to the right, we achieve great success in the matter of replacement. I think this is a matter of such importance that I feel like emphasizing it. Of course, should there be adhesions the rule does not apply. The remarks made by Dr. Betts in regard to the source of lesions in the tubes is important. I have a case in mind where a young lady above suspicion as regards any possibility of infection has long been subject to in-

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flammatory processes in the Fallopian tubes and ovaries. She is ruined in health, and I suppose removal will be the only cure ultimately.

B. F. Betts, M.D.: I cannot say that my personal experience allows me to fully endorse the method of replacement just spoken of by our colleague, Doctor Morgan, although he is correct in speaking of the direction the uterus takes in becoming displaced.

CERTAIN MENTAL AND PHYSIOLOGICAL CHANGES FOLLOWING REMOVAL OF THE OVARIES.

GEORGE W. SMITH, M.D.

In presenting a paper on this subject, it will be well for me to mention certain facts which are familiar to you all, but to which your attention should be directed in order to thoroughly understand certain phenomena herein described. These facts are the anomalous relations between the two sexes as to their origin, development, functions, etc.

All the sexual organs of the female have their analogues in the male and their formations are identically the same. Thus the clitoris of the female corresponds with the penis of the male; the labia-majora with the scrotum; the ovaries with the testicles, etc. Courty states that "At the beginning, the development of the internal generative organs takes place around the Wolffian bodies. These bodies atrophy towards the end of the second month and new organs are developed in the same region. These are the kidneys, the ovaries or the testicles, etc. Along the inner border of the Wolffian body there is a fusiform enlargement, which, increasing gradually in size and diminishing in length, forms the first rudiment of the testicle or ovary. Along the external border, parallel with and attached to its excretory duct but quite independent of the tubes, there is a second organ, at first a simple, solid cord, later hollowed into a canal known by the name of Muller's duct. The excre-

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tory canal of the Wolffian body and Muller's duct both run into the cloaca." Now, according to Rathke and Cobelt, whilst the sperm duct is developed from the excretory canal of the Wolffian body, the oviduct proceeds from Muller's duct.

"In the first period of intra-uterine life, there is a time when the distinction of sex is impossible. This confusion is owing to the similarity of form, which soon disappears in the internal as well as in the external organs.

"If Muller's duct atrophies, Wolff's excretory duct forms a sperm-duct and is united by means of tubes, afterwards transformed into the epididymis with the germinative organ which becomes the male generative organ or testicle. If Muller's duct is developed it forms an oviduct, develops at its extremity a Fallopian tube, and remains distinct from the germinative organ or ovary. Therefore, according to the form of development affected by Muller's duct, or the Wolffian ducts, an oviduct or sperm-duct is produced and concurrently with it an ovary or a testicle." The development of the other sexual organs can be also traced out, but it is not necessary in relation to this paper.

The sexual organs of the male are formed for the express purpose of giving, and those of the female for that of receiving; yet, still, there is a great similarity in their conditions during the time of sexual excitement. Both sets of organs become congested, causing in the male the erect penis, and in the female an erection of the clitoris, an engorgement of the glands around the vagina and of the body of the uterus, producing a straightening out of that organ so as to facilitate the receiving of the spermatic fluid when it is injected into the vagina. The urethra and ejaculatory ducts seem to be the canal for transmitting the sexual fluid from the male, whilst the vagina, uterus and Fallopian tubes constitute a corresponding canal in the female for receiving the same. The organs of the male secrete the semen and inject it, whilst the sexual fluids of the female seem to be secreted for the purpose of moistening the parts, and the mucous lining immediately sets up a peristaltic action for the purpose of drawing the semen within the cavity of the uterus. Friction or irritation of the glans penis in the male or

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of the clitoris in the female will produce sexual orgasm, but it can very easily be demonstrated that the organs controlling these sexual phenomena are the testicles in the male and the ovaries in the female, for by the removal of these organs the producing power of sexual excitement is destroyed.

The sexual fluids of the female and the organs from which they were discharged were examined into very carefully by a friend of mine, and, according to his statement, after having inserted a speculum into the vagina, he irritated the clitoris by titillation until he had produced sexual orgasm, when he noticed the fluids escaping from the glands around the mouth of the vagina, but he could discover none from the os uteri. The os, however, became relaxed and exhibited a peculiar motion, as though it were endeavoring to draw in any fluids that might be injected within the vagina, but evidently the ovaries were actively excited and it was apparently from them that the nervous orgasm was directed. Before proceeding further, it would be well to suggest that sexual excitement is produced not only in the presence of or by contact with the opposite sex, but by imagination and brain power, and by artificial friction and revelry of the mind in lascivious thoughts the glands respond in producing sexual erethism; and by continuing this habit of masturbation, or even by over-sexual indulgence, the brain loses its tonicity, the mind becomes weakened and the sensibilities are blunted, leading us to the conclusion that, although the brain controls the sexual organs, yet, at the same time, certain controlling influences are reflected back upon the brain and many of its sensibilities are affected by the irritation, disease or removal of those organs.

These facts and relations have been thus traced to corroborate certain conclusions concerning the identity of conditions produced in the two sexes by the removal of the ovaries from the female or the testicles from the male. We are all familiar with the various accounts of the eunuchs of the East. How their physical condition remains unimpaired and, in fact, often improved, and those powers greatly enhanced; but their mental condition is always depraved, their minds uncultured, their sensibilities blunted, their affections destroyed, and their pleas-

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ures and usefulness greatly circumscribed. Now, if such is the case in the male, may we not also look for the same condition in the female? The removal of the testicles prevents the engorgement and consequent erection of the penis. Would it not also follow from the analogous relations between the testicles and the ovaries that the removal of the latter would prevent the engorgement and excitability of the clitoris, the erectile tissues of the uterus and of the vaginal glands? And although the presence of the vaginal canal would not prevent coitus, as the absence of the testicles does in the male, yet the absence of excitability or irritation to these various structures would certainly destroy all sexual erethism or pleasure. Whereas the sexual instincts and gratifications are but one of the blessings which are given to the human race, and should be indulged in only in moderation and according to the restrictions of morality and law, yet, as this is the seat of such strong emotions, does it not more or less control the brain, the affections, and the capacity of enjoying life in the other various and proper channels?

These questions were all so strongly impressed upon my mind that I concluded to discover, if possible, the practical solution whenever it became my fortune to meet with those who could thus practically inform me. I will first briefly state that the partial removal of these organs, that is, the removal of one testicle from the male or of one ovary from the female, did not seem to destroy the ability to perform the sexual act or of producing offspring. The first case with which I met was that of a man who had one of his testicles mashed, and gangrene having set in, his attending physician decided to remove the diseased organ, but before operating he called in three other consultants, of whom I was one. After deciding that it was the only hope of saving his life the testicle was removed, and the man made a happy and perfect recovery. After being restored to health, he found he was able to perform the sexual act, and in course of time his family was increased by a living and healthy child. The same experience was noticed after the removal of the right ovary from a woman, the wife of a policeman. After recovery she had the same affection for her hus-

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band and children, and enjoyed the sexual act as much as formerly. She conceived readily and gave birth to living and healthy children. These children are of both sexes—two girls and one boy—thus showing little, if any, abnormality by the removal of but one ovary or testicle. But such has not been the experience of those with whom I have met who have had both ovaries removed. My first case was a woman of fine physique, about thirty years of age, black hair and eyes, ruddy complexion, and apparently healthy and robust. I met her at the house of one of my patients, and in course of conversation she told me that her ovaries had been removed, and incidentally remarked that she would like to have the pleasure of removing the doctor's who had performed the operation. I asked her if she would object to my asking her a few questions, and she replied that she would willingly answer all my questions truthfully and conscientiously. I first asked her if she had lost all sexual desire or feeling, and she said: "Yes; I never want my husband to come near me." "Do you still have the same affection for him as before the operation?" "No; I never care to see him." "But you love your children as much as ever?" "No; I never want them around. They annoy and aggravate me." "How about society? Do you still enjoy company?" "No; I don't want to see anybody. I prefer to be by myself." "When by yourself do you read and enjoy books?" "No; I don't take interest any more in books, theatres, nor, in fact, in anything, as formerly. I want to be let alone and brood over my condition. In fact, I feel hard-hearted and cruel, and care for nobody but myself."

Case II. Young girl about twenty years of age came to my office in company with a patient, the latter of whom informed me that her friend had some time previously recovered from this operation. Upon my expressing a desire for certain information, the young lady willingly answered all my questions, which elicited these facts: That she had become selfish and careless, took no interest in society nor in any of the pursuits which she had formerly enjoyed; felt no affection for her former friends, and seemed to care only for those things which gratified her personal desires, such as food, sleep, etc. Although

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she still had some love for dress, she said her disposition was completely changed, and she acknowledged a want of sympathy or kindly feeling towards others.

Case III. Young woman, twenty-eight years of age, says she had both ovaries removed, and claims that, whereas, before the operation she never enjoyed sexual pleasure, now she cannot get enough. She has a delicate husband, and a small child about five years of age, and not satisfied with her home pleasures she goes out almost every night. From personal observation I place very little confidence in what she says. She is becoming very coarse and unwomanly in her appearance. Her voice is changing rapidly and becoming coarse and rough, and she has evidently lost all feelings of modesty and refinement, as well as kindness of heart or affection for her family. This is evidenced by the fact that almost every night she locks her little child in the house alone and carouses around till long after midnight. And I am inclined to think that she does not enjoy complete sexual erethism, but rather coarseness and obscenity, and that her pleasure consists more in gratifying the appetite for drink and lewdness; and although her assertion that sexual passion is present with her may be true in a sense, from what I have seen in this case I am strongly of the opinion that, if true, it is more in the nature of an unsatisfied craving for something incapable of full gratification, which leads her in the direction of sexual perversion. The changes which have taken place in her physical character and in her whole altered appearance make it obvious that some perversion of nerve-functions has been produced by the operation quite different from anything characteristic of the sexual feelings. In a case which came under my own personal observation some years ago, namely, the castration of a stallion, the spermatic cords were cut very long, and he was subsequently capable of having a complete erection, and strong but exceedingly evanescent sexual passion which was incapable of complete gratification. He was always ready to attempt coitus, but before the act could be commenced the erection disappeared. In a female, of course, the irritation might possibly be indefinitely prolonged, but without practical results manifesting themselves very much in the

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phenomenon, as I believe to be the case with this woman whom I have just described. I have had no opportunity to discover how this operation was performed, nor do I know what would be the result of removing merely the ovaries and leaving their closely adjacent organs behind. But it is certain that the clitoris and the ovaries coact with each other by means of some connection of an intimate and exceedingly powerful character, and I would like very much to have some of those present endeavor to throw light on the nature of this connection, and in what way the removal of the ovaries themselves, while leaving intact the parts immediately adjacent thereto through which this communication is established, whether tubular, vascular, glandular, nervous, or whether mere interstitial tissue, may modify the results of such operations. I would also like very much to know the nature of these adjacent organs, for I know that such exist—among others a sort of a gridiron arrangement which I have never been able to trace out or discover, by reading, the nature or functions.

I consider that there is a wide field here for the physiologist and the pathologist which has never been explored, and of which the importance to the physical, moral and sexual welfare of mankind cannot be exaggerated.

DISCUSSION.

ISAAC CROWTHER, M.D.: I would like to ask the gynæcological surgeons present whether sexual desire or appetite entirely disappears after removal of the ovaries, as I have a case in point having a legal bearing.

BUSHROD W. JAMES, M.D.: As bearing on this subject, I will state that I had a case some time ago in which there was no marked change mentally. The operation for the removal of the ovaries was performed six years ago, and she now seems to be enjoying all the healthy enjoyments of life without any change in her temperament, so far as the general conditions of life are concerned. I have not seen her for some time, but the last time I did see her she had not shown any change mentally, morally, or physically, or in her voice, years after the operation.

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JOHN E. JAMES, M.D.: While I heartily endorse the paper just read and the able remarks of my colleagues, I wish to make a distinction between removal of organs in the male or female before full development has taken place, and their removal after maturity. As there is a corresponding growth in the mind and the body with the development of the organs of generation, I consider the premature removal of such important organs liable to stunt the growth and expansion of mental and moral processes as well as physical development of muscle and brain. I think there has been too great a tendency to remove these organs without sufficient reason; but when we have sufficient evidence that an ovary is diseased and has lost its function, it is of no more use to the body, and should be removed just as quickly as we would remove a suppurating eye to save the other one. Now, as to the mental changes spoken of in this paper, those are all true. To remove a diseased ovary that has been a long time diseased, we all expect a change in the nervous system and a certain train of symptoms to follow. I have no doubt that these organs are faithfully removed with a hope of improvement. We cannot know whether the mental condition resulting will be more pronounced than the physical. I advise the operation, not always knowing whether I will get good or bad results, and the patients must take the risk.

A REMEDY USEFUL IN CLIMACTERIC FLUSHING.

BY EMMA T. SCHREINER, M.D., PHILADELPHIA.

THE flushing of the climacteric period is often accepted by women as inevitable, with only time to be looked to for relief. I find so little notice taken of any other than surgical diseases belonging to this period of life that it seems medical men also are inclined to commit the care of these functional disturbances to Father Time. While flushing, with its accompanying nervous depression or irritability, does not often incapacitate a woman for work, it makes her life a burden and prospective

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dissolution a boon. If the promotion of happiness is worthy of consideration, anything which will relieve this ephemeral discomfort is valuable. Free perspiration is doubtless physiological and beneficial, but these sudden overwhelming attacks of heat and perspiration are not physiological. That old classic, Tilt, on "Change of Life," attributes the sweats of the climacteric to the subsidence of ovarian stimulus, causing depression of nervous power and permitting paralysis of the vaso-motor nerves of the skin, thus causing it to sweat; causing also the sudden and irregular changes from heat to cold, or continuous cold, and clammy perspiration without heat. If the habits of life are correct enough, nerve-stimulus is provided for all normal functions at all times; but where the sympathetic nervous system is disordered, as in visceral disease, or depressed under continual strain, nerve-power will be lacking. A woman living hygienically should escape all climacteric trouble just as a healthy girl passes into womanhood without a pang; but too often women approaching the climacteric are worn out, and with cares accumulated, instead of dropping, as they should, upon younger shoulders. If at this period healthy women can have rest and change of scene and occupation, the change of life becomes a source of joy rather than of sorrow, and the tranquillity and peace of middle life may confer more of blessing than the lost attributes of youth.

One class of women suffer at the climacteric through being overworked and worn out; another class from too luxurious ease.

Through over-indulgence in the pleasures of the table, and insufficient exercise, the sympathetic nervous system is overtaxed and gives way, just as it does under too much labor and care. If you would do one of these luxurious ones an especial favor deprive her of her carriage, make her do all her own errands on foot or on a bicycle. She will perspire and get tired, and perhaps cross, at first, but she will soon learn to like the exercise and recognize the benefit which it confers.

It is in this class of women, where stoutness and apparent plethora would in old times have suggested bleeding, that I have oftenest seen marked relief of flushing and perspiration

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from aconite. The violent but transient excitement of the vaso-motor and sudden filling of the peripheral capillaries in climacteric flushing are certainly suggestive of the action of aconite, as is also the relief by perspiration. The mental symptoms will be frequently found to correspond with those of this drug, also the conditions of amelioration and aggravation, the climacteric condition being markedly aggravated by violent emotions, anxiety, or the use of stimulants.

Plethoric cases are not the only cases to which aconite is applicable. The first case in which I noticed marked relief from this drug of flushing, nervousness and general climacteric distress was that of a lady, tall and slender, so thin and pale that she seemed not to have a drop of blood to spare. She was dark and bilious-looking, and came to me for medicine for a cold. I saw that she was extremely nervous, and she mentioned incidentally that her life was a burden, owing to these dreadful flushes. I said I would give her something for that also, and prescribed aconite, with sulphur to follow. I did not see the lady again for a month; then she came for more of the medicine for flushes. She said it acted like a charm, so she had not taken the second medicine (sulph.) at all. I gave her more aconite, and she afterwards asked nothing better than to keep it on hand, finding an occasional dose sufficient to keep her in comparative comfort.

SYNOPSIS OF OPERATIONS IN GYNÆCOLOGICAL CLINIC OF THE HAHNEMANN MEDICAL COLLEGE DURING THE SESSION OF 1895 AND 1896.

JOHN E. JAMES, M.D., PHILADELPHIA.

THE operations in the Gynæcological Clinic, Session 1895–96, numbered 97, including oöphorectomies, 18 double and 4 single; abdominal hysterectomies, 5; tuberculous inflammation, with extensive adhesions, 1 section; vaginal hysterectomies, 6; total

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capital operations, 34; cervicorrhaphies and trachelorrhaphies, 10; other operations (dilation, curettements, small tumors, etc.), 43; deaths, 1; mortality, 1.03%. Clinical cases are usually the most unpromising, especially when the operations are done in a large amphitheatre, even with the best possible conditions that can be secured in such a place.

The technique at all times was a careful asepsis for room, patient, operator, assistants, nurses, etc.; no antiseptic was used after the operation began.

The closure of all abdominal wounds, except one, was by three rows of sutures; fine silk or catgut was used to close the peritonæum, silver-wire to close sheath of recti muscles, and silk-worm gut for the skin. The one exception was in a case of a very large fibroid with great shock, requiring unusual haste, in which a single row of silk-worm gut, each stitch including the peritonæum, was used.

No hernia has followed any case, and in but one case did the wire have to be removed, and that was the only case in which primary union did not take place. She had severe secondary shock, with paralysis of bowels, lasting three days, which was finally overcome by internal use of croton oil. Rectum was feeble afterwards, with a stitch-abscess; it exposed the wire-suture, which was removed, the wound cleaned and packed with gauze; it healed kindly by granulation.

In most of the cases gas was passed freely and bowels moved in about twenty-four hours, in answer to enema or small cathartics followed by enema.

Very large fibroids are now quite rare, yet two of these series weighed twenty-five pounds each, one globular and of slow growth, the other oblong and of more rapid growth, and microscopically confirmed as an œdematous fibroid, a rare variety.

The one death was in a case operated with a hope of saving what promised only a fatal issue, from septic peritonitis. Case age 31; four days before admission, while washing on a cold day and during her menstruation, was suddenly attacked with severe pain in left side of abdomen, followed by severe peritonitis. Bimanual examination revealed large, tender and painful mass in left iliac region, with large fluctuating mass in right side,

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closely related to the uterus, with general peritonitis. She did not improve, and on third day, on opening abdomen, found a ruptured fibro-ovarian abscess, left side, and a cyst of right broad ligament, containing about a pint of fluid. Adhesive extension but recent, adhesion broken up; both tubes and ovaries removed and cyst enucleated, abdomen freely irrigated and drained with glass tube, and iodoform gauze. There was considerable oozing, reaction good, bowels moved in twenty-four hours, no increase of peritonitis, no distention of abdomen. She continued the same characteristic course as before the operation, gradually weakened, and died on twelfth day after operation, of septic peritonitis from infection before operation.

DISCUSSION.

I. G. SMEDLEY, M.D.: One of the important points in the paper which I consider of interest is that of the permanent suture preventing any hernia. In the spring of 1895 I was visiting the Johns Hopkins University, at Baltimore (Dr. Kelly's clinic), when I saw them use the silver wire as permanent sutures, claiming silver to be germicidal, and had no bad results from the use of such permanent sutures. Again, in the fall of 1895, they were still using them with no bad effects; and they have had them in continuous use ever since. The method of using them was described in the paper by Dr. James. I had a case of stitch-abscess occurring in a private patient, and I suspected infection from somewhere. I found out afterwards that we had used impure water during the operation. I believe they are valuable as they give no pain, no inconvenience. The deep stitch of silk-worm gut only pulls the muscle and the general fascia together, and not the aponeurosis of the muscle; and the wire brings the aponeurosis together and holds it there after it is needed.

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REPORT OF THE BUREAU OF PATHOLOGY AND PATHOLOGICAL ANATOMY.

The Relation of the Pancreas to Diabetes Mellitus, by F. Mortimer Lawrence, M.D.

THE RELATION OF THE PANCREAS TO DIABETES MELLITUS.

DR. F. MORTIMER LAWRENCE, PHILADELPHIA.

In no department of research, possibly excepting that of the nervous system, have the investigations of modern physiologists been more richly rewarded than in the attempt to explain the functions of the glands of the human body. For instance, in the undergraduate days of even the younger of us the lecturer passed over the functions of the thyroid with scarcely more than a surmise as to its part in the economy of life; and yet to-day physiology and pathology have united with therapeutics in attributing to it an importance second only to that of the heart itself. Not only has pathology asserted that its failure to empty a normal amount of a yet unknown ferment into the circulation will produce myxœdema, but therapeutics has proven it so by repeatedly curing myxœdema by means of thyroid-feeding. And in addition, neurology stands ready to disclaim the purely neurotic origin of exophthalmic goitre, attributing it instead to an over-secretion on the part of the thyroid—to be cured, other means failing, by the removal of a portion of that gland.

But it is not with the thyroid, but with the pancreas in its relation to diabetes mellitus, that this paper treats. As is well known, we have a number of distinct pathological conditions which clinically express themselves by glycosuria, and in consequence are still classified under the generic term of diabetes mellitus. Etiologically, however, these forms are widely sepa-

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rated: among others we have the cerebral, experimentally produced by irritation of the floor of the fourth ventricle, the dietetic, the hepatic and the pancreatic. All, as I have said, are characterized by sugar in the urine, but beyond that they have so little in common that our present nomenclature is disastrously confusing. The prognosis varies as widely as the ætiology, according to the form; and certainly there can be no scientific treatment until the latter is taken into account.

Until very recent years our knowledge of the pancreas was confined to that of the triple action of its juice in the digestive process. Then by degrees it was learned that in some indefinite way it was occasionally associated with the phenomenon of glycosuria. As long ago as 1877 Prof. Lancereaux exhibited before the Paris Academy morbid specimens of the spleen from diabetics, and two years later Lapierre confirmed his observations. The latter demonstrated that out of twenty fatal cases fourteen showed atrophy of the pancreas. Year by year other eminent investigators have embraced this view, until now it may be said to be the accepted theory that true diabetes mellitus invariably results from degenerative or destructive lesions of the pancreas, as the result of which it is rendered impossible for that gland to empty into the circulation a glycolytic ferment whose presence in the blood in some way determines the destruction of its normally-contained sugar.

The results of all recent experimentation on the lower animals but tend to confirm us in this view. For instance, Prof. Lepine has recorded forty cases of removal of the pancreas in dogs, in all of which he noted the appearance of sugar in the urine within forty-eight hours, and the condition was permanent. "He believes that the blood has the power of constantly destroying glucose by the action of a ferment made in the pancreas (glycolytic ferment). This ferment is diminished in diseases of the pancreas, and wanting when that gland is destroyed."

Numerous other investigators have come to similar conclusions. Hedon excised the pancreas in twenty-two dogs, and in each case diabetic urine was passed the following day, and this persisted until death, with all the symptoms of saccharine diabetes. According to Minkowsky diabetes never fails to follow

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complete removal of the pancreas. This statement is founded upon fifty-five experiments on dogs: three times only did sugar fail to appear in the urine, and in these cases the dogs succumbed in the first twenty-four hours. Moreover, this experimenter demonstrated that if a portion of the pancreas was transplanted beneath the peritonæum of one of these animals glycosuria was averted, and would appear only upon the removal of the transplanted organ.

The causes of pancreatic destruction in the human being vary from proliferation of connective tissue to tumors and calculi, but by far the most common condition is that of simple atrophy. So many similar observations have been reported that I might greatly multiply the proofs showing that such a condition inevitably results in diabetes mellitus. Moreover, although it is impossible of invariable demonstration, I believe that we are justified in considering every case of grave (lean) diabetes to be associated with pancreatic changes which prevent the normal secretion of sugar-destroying ferment.

"But," you will ask, "does this knowledge bring us any nearer to that goal of all true medical progress, the cure of a hitherto hopeless disease?" If analogy counts for anything, assuredly it does. As in the case of the thyroid, the results of drug treatment give us little encouragement: the best they can offer will be an arrest of the morbid process. But a perfectly rational treatment, and a hopeful one, offers itself; that having for its object the supplying of a substitute for the lost pancreatic secretion. This may be accomplished by the preparation of an artificial ferment, or by the extraction from the pancreas of its natural secretion.

The first method has been attempted by Prof. Lepine, who prepared an extract from malt. In four cases reported by him, in which this preparation was used, there was distinct improvement; the amount of sugar excreted daily was greatly diminished, but the effect was only temporary.

Pancreatic extract has been used experimentally by Prof. Torup, of the University of Christiania, in the case of dogs rendered diabetic by extirpation of the pancreas. As the result of the injection of pancreatic extract, sugar absolutely dis-

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appeared from the blood, and remained absent during the continuance of the injections. Unfortunately, however, the extract when administered by the mouth was inefficacious, it probably being destroyed in the stomach.

As applied to diabetes in man, a glycerine extract of the pancreas used by Ballistini in two hundred cases caused marked improvement in each instance; and other evidence of an equally encouraging character is accumulating. In these cases the injections were made directly into the veins, a procedure which, while controlling the diabetes, is decidedly dangerous. As yet apparently no other method has been attempted, but *à priori* it is reasonable to assume that the use of subcutaneous rather than intravenous injections of some modified preparation of this extract might aid in the solution of the problem. Pancreatic grafting has been suggested, but the probability of the early atrophy of the transplanted gland renders such a radical procedure scarcely justifiable.

Though the solution of our problem is by no means in sight, yet the experiments and their results warrant a reasonable expectation that at an early date much will be done to rescue a class of hitherto hopeless sufferers from the realm of the incurable, and we may agree with Prof. Lepine that theoretically the treatment of diabetes mellitus has been discovered. Many details remain to be perfected, but it would seem that the time is near at hand when diabetes, like myxœdema, will have been conquered by our increasing knowledge of the subtle chemistry of the human body.

DISCUSSION.

BUSHROD W. JAMES, M.D.: I have noticed with interest the points brought forth in the paper just read, but I wish to state that I have seen a number of cases get well under homœopathic treatment, the sugar diminish, and the test to show its final disappearance. In regard to the question of placing the patient under what is known as diabetic diet in this condition, I think it is better not to do so, from the fact that it is not an accurate test of the action of the remedies used in the disease. I think if you treat your cases homœopathically, watch care-

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fully the action of the remedies used, and go on with the usual diet, you will get better results, and will understand the case better than from any other procedure, for we know that there is a diminished amount of glucose simply from the kind of restrictive food alone, and the remedial action in its curative effort is thus masked.

JOHN C. MORGAN, M.D.: I am interested in this paper, and I think it would have been more complete had the writer alluded to other pathological sources of sugar in the urine. It is well known that the pancreas and liver, as well as the medulla oblongata, have a certain connection with diabetes mellitus. We all know the experiment of Bernard of puncturing the medulla oblongata and producing sugar in the urine of a dog. We also know that ordinary pathological lesions there have been attended with diabetes, and, besides, that there have been cases in which no lesions in the other organs have been found to exist where the liver was evidently at fault. The liver is the great sugar-producing organ in the body, and if this function is exercised in excess, it is only reasonable to expect that we will have sugar in the urine and diabetes; and if we undertake to treat the disease we will have to lay aside the significance of its name and find out the true source of the trouble, whether hepatic, pancreatic, or from a lesion in the medulla. The centric symtoms, subjective and objective, will no doubt enable you to ascertain the real central location of the morbid processes. If we get that matter thoroughly in mind, and get our proper classification of diabetes mellitus, I think we will advance in our treatment. Nevertheless, Dr. James has very properly spoken in favor of homœopathic remedies. There are some remedies which seem to be of general utility. I do not believe in giving a long-protracted diabetic course. I think Dr. James is correct. We should first endeavor to locate the lesion, after which we will be in a better condition to make progress in our treatment.

JOSEPH C. GUERNSEY, M.D.: For several years I have been investigating urinary analysis, and I found great difficulty in getting accurate tests for a small amount of sugar. Fermentation will not give closer than one-half of one per cent. Last winter

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I found a very delicate test which gives one-tenth of one per cent. of sugar. You proceed as follows: Filter the suspected urine through granulated or pulverized charcoal; it must be filtered three times, and after the third filtration of the urine, no matter what the color was, no matter how much albumen is in it, it comes out as clear as the purest spring water. Then take two drachms of the filtered urine, warm the upper portion, and add to this one drop of the test solution (Haines's), which will instantly show you the presence of sugar, even should it exist in the most minute quantity. I am sorry that I have not the proper appliances and apparatus to make this experiment before you this morning. I have discussed this test with a prominent microscopist, and we consider it the most delicate test for sugar. I have been fortunate enough to obtain one-twelfth of one per cent. of sugar in my experiments.

(Dr. Guernsey later made the tests referred to, being markedly successful in demonstrating the presence, in a sample of urine, of a minute quantity of sugar.)

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REPORT OF THE BUREAU OF PÆDOLOGY.

Preputial Adhesions in Little Girls, by M. Margaret Hassler, M.D.
Marasmus, by J. E. Harner, M.D.
Enuresis in Children, by W. H. Cooper, M.D.
Heredity and Its Modifications in Childhood, by C. A. Yocum, M.D.
Cases of Tubercular Meningitis Cured With Iodoform, by W. J. Martin, M.D.
Some Thoughts on the Chest Diseases of Children, by Mary A Cooke, M.D.
The Mosaic Rite of Circumcision—A Plea for its Performance During Childhood, by S. G. A. Brown, M.D.
Erysipelas in Infancy, by Julia Gould Waylan, M.D.

PREPUTIAL ADHESIONS IN LITTLE GIRLS.

M. MARGARET HASSLER, M.D., ALLENTOWN, PA.

MANY physicians are awakened to the importance of circumcision, knowing how mischievous the adhesion of the foreskin to the glans penis is in the male, causing the convulsions, dropsies, paralysis, insomnia, eczema, kidney troubles and outgrowths of masturbation, and here a plea should be made for the girls. This paper is to treat only of preputial adhesions in little girls; but all-round orificial work is urged in every case showing any degree of orificial pathology at the lower orifices of the body. It may be profitable to describe the analogy of the clitoris and its prepuce to the glans penis.

(1) Both are erectile. (2) Both consist of a glans, a body, two crura. (3) They each have corpora cavernosa, separated by an incomplete septum. (4) The glans in each is partly covered with a prepuce, with a frenum attached below. (5) Each is supplied by filaments from the pudic nerve and hypogastric plexus. (6) Each produces a cheesy secretion called smegma, which accumulates and hardens under the prepuce. "Small as this organ is, compared to the glans penis, it has in

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proportion to its size four or five times the nerve supply of the latter."

Many years ago the French physicians recognized the clitoris as a source of nerve waste in women. Their measure for relief was so radical as to cause harm instead of good. They amputated the labia minora, the hood of the clitoris and clitoris itself. The result was a relief, but with it a relief from all normal sexual instincts, and so frequently followed by insanity, that the question of the practice was a subject for legislative action, and amputation of the pudenda was forbidden by law.

An improper growth of child, imperfect speech, eczema, disordered stomach and bowels, weakened mind, enuresis and other derangements call for an examination if they do not yield to properly chosen remedies. One often finds young children with the clitoris entirely covered by its hood and the vagina closed with a thin membrane. An adherent hood may produce such an impression upon the nerve-centres as to cause degeneration of the entire sexual system. Where it has existed from infancy to puberty we often find evidences of uterine and ovarian disturbances caused by it. In adult life the adherent hood is not found so frequently. This is explained by the fact that the irritation of this part from any cause attracts attention to that part and leads to habits which sooner or later frees the prepuce. A few cases in children have come to my notice where there was no sign of a clitoris at all. In all cases, when operating, care should be taken to prevent as bad if not a worse condition than first found. A pinching clitoris hood should be liberated by an incision, or retraction, or amputation. If there is the slightest opening, or even a red line to mark the place for opening, the clitoris can often be freed from its hood without even a scratch to cause the blood to appear. As in cases of the male, the confined smegma aids much in the operation. In some cases the skin can be pinched up with a pair of forceps, so as not to injure the organ, and a small portion cut off. With a tenaculum the underlying tissues are raised and separated properly. Liberate all smegma and dress parts with Peruvian balsam and castor oil. While the parts are healing see to it that no adhesions are being formed. The results that

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follow the perfect freeing of an adhered clitoris have been in many cases immediate and astonishing, in others not so marked. This can be endorsed by those who have not been influenced by fancy or theory, but from personal observation.

When doctors realize that the clitoris and its hood are supplied by the same set of nerves, subject to the same laws of action and reaction, and the abnormalities of the hood of the clitoris are as mischievous as those of the foreskin, we will have fewer records of failure in the treatment of children's and women's diseases.

CASE I.—Mary H., age 3 years; very changeable, with no control of urine; leucorrhœa. Examination revealed clitoris completely covered and bound tight with its hood. This I freed with the use of cocaine; enuresis and leucorrhœa have left her and she has become a sweet little girl.

CASE II.—Bessie M., age 6 years. Was sent to me a year ago. Had been having convulsions for three years every three to four weeks, but became more frequent; looked demented, could not stand. Examination showed an irritable vagina and adhesion of hood to clitoris, with a deposit of hardened smegma. Operation consisted in freeing the clitoris; after treatment, cleansing the vagina with warm water and hydrastis wash. Child recovered, gained in flesh, and becoming as bright as her sister, was sent to school. Improvement lasted six months, when convulsions returned. Upon examination found the hood completely covering clitoris and grown together, forming a cicatrix. I broke this up; amputated hood, which was too long. Since then have had no trouble. The cause of failure to cure upon first operating I believe to be poor work on my part. The relief obtained after the first operation shows us that if the case is properly handled a complete recovery will be the result.

CASE III.—C. A., age 4; could not walk, enuresis, lateral curvature of spine. Hood was found adherent on one side; enlarged, congested and ulcerated clitoris. This was freed, and signs of improvement were noticed in a month's time, and in several months' time the child walked, enuresis ceased, curvature improved.

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CASE IV.—Annie M., age 9; had chorea for two years; found hood adhered, completely covering clitoris; freed this, and in two weeks patient could walk without falling, and has been in good health since.

CASE V.—Emma M., age 5; anæmic, irritable, indigestion; could not walk steadily. Loosened hood of clitoris, which was adherent on side only. Improved fast, and three months later was well.

It is our duty, as physicians, not only to restore the lost, but to prevent the destruction and save our girls from the gradual invalidism to which so many are heirs to at puberty or soon thereafter.

MARASMUS.

J. E. HARNER, M.D., SCRANTON, PA.

WHEN informed months ago that I had been appointed to write a paper upon some subject pertaining to diseases of children, to be read at the meeting of the "State Society," the time seemed so distant that I gave it very little thought. But we often realize, as I did in this case, that "Time flies," for it did not seem long until I received a note from the Chairman of the Bureau of Pædology, requesting me to send him the title of my paper. I still procrastinated, until I received another note asking me if I would not write a paper upon Marasmus, when, without any consideration, I replied "Yes," thinking that probably I knew as much about marasmus as any other subject. But when I came to consider it, and to think of the little ones I had treated, suffering from this trouble, I found my experience had been very limited in my fourteen years of practice, as I feel confident I can count all the cases of marasmus I ever treated upon the fingers of one hand Just why I have been so fortunate, or unfortunate, in being called upon to treat so few troubles of this kind I cannot say, unless it is because all those years of my practice, excepting the last eighteen months, have been confined to practicing in the country, where we do not

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meet with so many of them as in the towns and cities. Also, my practice was confined to the County of Chester, which I think is noted for its healthy mothers and babies—and which, also, is famed for its many fine dairies of blooded cows. Hence probably the reason I have not met with more cases. Therefore all I hope to be able to accomplish by this paper is to touch upon some point which will lead to a discussion of the subject, or cause some one to think of something of which he otherwise would not have thought, and probably I will go home knowing considerably more about marasmus than when I came.

By marasmus we understand a gradual and continuous ous wasting away of the bulk of the body from some morbid cause. Now this condition may result from the unhealthy or unsuitable character of the food with which the little one is supplied, or from its own inability to assimilate, on account of some inherent hereditary disease. Therefore it is very necessary for the physician to determine to which of these two classes the case belongs, and this at times is no easy task. We find this disease most common in the first year of life, but it may occur in the second year, and its enfeebling effects upon the constitution may last very long. The food is either too limited in quantity, is indigestible, or else supplied in a form in which the ingredients are not properly balanced. Breast-fed children are more apt to suffer from insufficient quantity, and bottle-fed babies from improper quality of food and overfeeding.

The treatment of marasmus is therefore essentially dietetic, and it behooves us to look carefully after the feeding. As a rule we find this atrophied condition in hand-fed babies, or at least that has been my experience. In but one case of my own did the mother nurse the babe. If we find the atrophied condition or marasmus develops after the child has begun to thrive, we may safely conclude that the character of the food is not what it should be, or else some other local cause is at work which we must remove. In these little ones the symptoms are various. Sometimes the food is rejected almost as soon as swallowed, or very soon after. The stools are undigested, or a pasty, cheesy substance, giving forth a very offen-

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sive odor. More often a diarrhœa of whitish-colored stools exists, indicating deficient action of the liver, or the stools may be variegated and too frequent and watery; often, too, there is an acid odor not only of the evacuations but also of the perspiration. There is the enlarged belly, often with a hardness which is unnatural with all this emaciation, while the skin takes on that old, shriveled look, sometimes dry and hot, at other times with a moist, flabby condition. But in any or all of these cases the child is peevish, restless, fretful, crying and whining as if continually distressed, which it is, and all the while growing thinner and thinner. The food which the child has not vomited passes through into the intestines in an imperfectly-digested condition, and thus transfers this distressing irritability throughout the entire digestive tract. As a rule I believe the great majority of little ones who suffer from marasmus are the ones who are artificially fed. Hence in this brief paper I will confine myself chiefly to those of that class who are not suffering from any hereditary disease. Therefore it will be the physician's first duty to find out and remove the primary cause, which very often, I believe, can be traced to improper food and irregular feeding. The digestive organs of a child favor the production of fermentation more than those of an adult. Its stomach can hardly be considered a muscular organ, and its relative size is very much smaller than that of an adult. Then, too, peristaltic action, which is such a valuable aid in digestion, is almost entirely wanting. The digestive juices are almost *nil*, because the glands which produce them are not developed. A common occurrence with mothers is to give the baby the bottle to keep it quiet. Now, when we consider that the capacity of the child's stomach at birth is about one ounce, is it surprising that they are over-fed and their little stomachs over-distended, and the bowels nearly bursting with gas, when we see a bottle containing three or four ounces full of food given to the little one whenever it cries? Therefore, impress upon the mother the necessity of regular feeding and the proper quantity to be given at each feeding.

I frequently give mothers the following tabulated list, viz.:

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At	2 weeks old,	1½	ounces every	2	hours.
"	1 month old,	2	"	2	"
"	3 months old,	4½	"	2	"
"	6 "	6	"	3	"
"	12 "	8	"	4	"

Although this cannot be followed in all our marasmus cases, yet it is a good guide for them. Next will come cleanliness. This must be particularly looked after. It has been my policy for years to do away with the long tube, and use only the nipple, for it is impossible to keep these tubes clean, especially in hot weather—and not only cleanliness as regards the bottle, but also as to the child's clothing; and never to permit a soiled garment, which probably has the odor of vomit upon it, to remain upon the child a minute. Let the mother be as careful about this as she would be about a soiled diaper.

Also plenty of good, pure, fresh air. Too often these little ones are confined in badly-lighted and illy-ventilated rooms. No detail should be considered too trivial for the physician's personal attention.

I think it is conceded that, aside from the mother's milk, sterilized or peptonized cow's milk, with *lime* and barley-water as diluents (the former preferred if there is vomiting or acid eructations), offers the best substitute. I had been taught to give the milk from one particular cow, but my opinion in regard to that has changed, and I now advise mixed milk to be given. Often when the milk, properly diluted, fails to nourish the babe, two or three teaspoonfuls of cream and half a teaspoonful of sugar of milk will be an aid, care being taken that too much sugar is not added. The condensed milk is often a good substitute for cow's milk. But my opinion is, that much of it contains too much sugar.

Then come our infant-foods. Some of them are valuable because their constituents nearly approach the composition of human milk, and others are worthless on account of the excess of saccharine and starchy matter they contain.

Now, as regards the *indicated remedy* we often hear so much about, I will only say that, as far as my experience goes in these

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cases, it has been as in all other diseases—very much aid is obtained from a selection of the proper remedy.

The following three cases are taken from *The North American Journal of Homœopathy*, February, 1891:

CASE I.—A babe, aged nine months, whose mother was of scrofulous diathesis, and whose older sister had died at the age of three months from inanition. The child had had diarrhœa for two months, stools of greenish mucus, and always accompanied by flatus. Abdomen distended; ravenous hunger; child had a very aged look. Argent. nit. 3x, one powder every four hours; after about nine days improvement began and went on to complete recovery.

CASE II.—Child six months old. Had been weak and sickly from birth. For two months past had been steadily growing worse, although everything had been done in the way of diet and change that could be done. Bowels at this time constipated and distended with flatus. Stomach seemed sore to touch. Had been given nux high and low, also *sul.* high. ℞. Argent. nit. 30x, five pellets, three times a day was prescribed. In five days the child was improved, and in six weeks was plump and healthy.

CASE III.—Was a babe, eleven months old, in pretty much same condition as Case I. There was this difference, viz., that Case III. was nursed by the mother. The baby was ordered to be weaned and cow's milk substituted. Arg. nit. 3x was given. Improvement began in less than a week and recovery was complete.

ENURESIS IN CHILDREN.

W. H. COOPER, M.D., OAKMONT, PA.

ENURESIS, in its widest latitude, signifies an involuntary urination arising from any cause whatsoever and occurring at any time. To classify—these may be *enuresis diurna*, when the act takes place during the day, *enuresis nocturna* occuring during

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the night only, and *enuresis diurna et nocturna* when the condition persists during both day and night.

The chief cause for incontinence in children is an incomplete development of the sphincter vesicæ. Both anal and vesical sphincters reach their full development towards the end of the second year. When incompetence of either, but especially that of the bladder, persists beyond that limit, while proper treatment may modify the condition very considerably, a complete recovery does not generally ensue before the age of puberty. Malformations and diseases of the genito-urinary apparatus are causative. Thus phimosis or a small meatus in males, a clitoris with adherent hood or polypoid excrescences at the neck of the bladder in females. One observer found the source of trouble in a malposition of the orifices of the ureters. Vesical calculi and cystitis are operative. Expansion of the bladder with urine is frequently a cause of nocturnal enuresis. This expansion may be due to polyuria or diabetes mellitus. Thus not only the amount, but also the changes in the chemical composition of urine, operate in incontinence, and albuminuria, glycosuria, hyperacidity, too highly concentrated urine are influential causes. Fissure ani, retained fæces, and ascarides (especially in female children) are sufficiently irritating to produce enuresis. Masturbation is not an uncommon cause. The constant irritation of the parts results in a chronic inflammation of the whole prostatic portion and neck of the bladder, becoming so sensitive as to yield very readily to the slightest *vis a tergo*. Cases have been ascribed to insufficient innervation. A child, so earnestly absorbed in play, may void urine from want of mental control. Epilepsy, the nervous disposition, restless sleep, dreams and night terrors often overcome the resistance of the sphincter and incontinence follows. Chorea contributes a cause by want of co-ordination between sphincter and detrusor. Enuresis in mouth-breathing children is accounted for by the slow carbonic-acid poisoning that follows such respiration. Anæmia, debility and constitutional disorders may have incontinence in their train of symptoms.

With such a variety of causes, it is evident that in order to establish a successful regime in enuresis, much tact and pa-

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tience must be exercised. The general health of the patient can be improved by cold sponge baths in the morning, followed by brisk frictions and massage. Feed the child on a diet that is at once nutritious and easily assimilated—avoiding, especially late in the day, liquids and such articles as are highly nitrogenous. Encourage the habit of evacuating the bowels before retiring; if necessary, assist in their evacuation by artificial means. Advise parents to waken the child when they retire, to enable it to empty its bladder and thus overcome the distention which would otherwise ensue. The interrupted electrical current should be applied locally in cases where the sphincter is weak—one electrode to the perinæum, the other to the hypogastrium or the lumbar region. *Nux vomica* is, perhaps, the best medicine here. Eliminate all local malformations and diseased conditions by surgical interference. In cases where the quantity and chemical quality of urine is at fault, a careful dietary and such remedies as *sulphur*, *the mercuries*, *phosphorus*, *phosphoric acid*, *uran. nit.*, *apis*, *lycopodium*, *arsenic* and its *combinations*, will prove effective. *Cina* and *santonine* will be beneficial where ascarides are operative. Cystitis, with enuresis as a symptom, will be helped by irrigating the bladder with solutions of permanganate of potash or boracic acid, and such remedies as *cantharis*, *berberis*, *terebinth* and *merc. sol.* For incontinence during the day, *ferrum phos.* has been lauded. *Bell.* and *hyos.* will often prove efficacious in nervous, easily-frightened children. *Causticum* and *equisetum* have been given without special indications, with success. Anæmia, debility, constitutional disorders are benefited by toning up the system, and such remedies as *sulphur*, the *calcareas*, the various *iodides*, *silicea*, *mercury* and *arsenic*. In cases where sleeping on the back is an exciting cause, much benefit will follow elevating the foot of the bed and thus overcoming the tendency of the urine to press on the most sensitive parts of the bladder. A fellow-practitioner cites a case of enuresis in a young man which disappeared after an attack of urethritis. On the same lines the injection of some caustic like nitrate of silver (in solution) into the prostatic urethra and neck of the bladder through a soft rubber catheter might prove efficacious.

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HEREDITY AND ITS MODIFICATIONS IN CHILDHOOD.

BY C. A. YOCUM, M.D., POTTSTOWN.

EVER since the fall of Adam the iniquity, as well as the righteousness, of the father has been visited on the son, and heredity in its varied forms and manifestations has either been blessing or cursing the children of men. It has either been ennobling, improving and elevating, by endowing them with healthy bodies and sound minds, or blasting, perverting and destroying the happiness and usefulness of its unfortunate victims. How many lives have been blighted, their lofty ambitions disappointed, their high aspirations crushed, and their fond hopes never realized, because of the transmission of some dread malady, some disorder or tendency, which has weakened the body, dimmed the intellect, crushed the hopes and rendered what might have been a happy, symmetrical and useful life but little more than a miserable existence?

The sum total of the diseases, vices and frailties which are the result of violated law, and which afflict not only the guilty, but likewise their innocent posterity, is too great to mention. They are so wide-reaching in their influence that they not only affect individuals and families, but doubtless have decided the destiny of states and nations. Likewise the blessings and benefits which descend through obedience to the laws of God are innumerable, and have come down through the ages, giving health, strength, happiness and peace to the generations of men who keep His commandments. What a grand heritage it is to have a godly, intelligent, pure, honest ancestry; to inherit their noble qualities, their powers of memory, mind and will, the rugged constitution, the steady nerve, the noble purposes, and, in a word, to receive all that is lofty, pure and good from a noble parentage.

But all are not so fortunate as to be the happy recipients of such a grand legacy. On the other hand, the vast majority of mankind have inherited the sad consequences of violated an-

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cestral laws, are victims of transmitted weakness, and seem to be unable to change their sad condition. It is to this class that the attention of the philanthropist, physician, and every one who is interested in the uplifting, emancipation and restoration of a fallen race, is directed. Can these unfortunate victims of the sure effects of violated law be restored to something like a normal physical and mental condition? There are many who believe that it is impossible to recover from the effects of violated law; that the consequences thereof must and will be indefinitely transmitted; that we are what we are because our ancestors have made us so; that we are powerless to change our sad condition; and that, in turn, it will be again transmitted to an unfortunate and helpless posterity, who will not be able to modify or escape from it, regardless of their desires, hopes and efforts to do so.

Some one has expressed this thought of incurable heredity in the following satirical poem:

Your strictures are unmerited,
Our follies are inherited;
  Directly from our grandpas they all came.
Our defects have been transmitted,
And we should be acquitted
  Of all responsibility and blame.

We are not depraved beginners,
But hereditary sinners,
  For our fathers never acted as they should.
'Tis the folly of our grandpas
That continually hampers.
  What a pity that our grandpas weren't good.

Yes, we'd all be reverend senators
If our depraved progenitors
  Had all been prudent, studious and wise;
But they were quite terrestrial,
Or we should be celestial;
  Yes, we'd all be proper tenants for the skies.

If we are not all blameless sages,
And beacons to the ages,
  And fit for principalities and powers,
If we do not guide and man it
And engineer the planet,
  'Tis the folly of our grandpas, and not ours.

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Many seem to think that we are entirely helpless and irresponsible; that we might just as well calmly accept the sad fact, and put forth no effort to ameliorate our condition.

But although we may be woefully degenerated and incapacitated by heredity, and, beside that, greatly handicapped by environment, we must not forget that we have volition, reason and judgment; we have time and opportunity, and the power to start anew, and to undo to a great extent the mischief that has been transmitted through many generations.

Although there may be notable exceptions to the rule, I thoroughly believe that the vast majority of inherited disorders and tendencies can be greatly modified if not entirely cured; and, furthermore, I believe that the most propitious time to commence this work of reconstruction is during the tender years of infancy and childhood, before the habits of life are formed and fixed; when the mind is impressionable and the will is pliable. This certainly is the time above all others when the foundations must be laid on which may be built a strong, healthy, noble character; the time when the operations must be commenced which shall resist, modify and eradicate any objectionable form of heredity that may be lurking in the system.

As it is less trouble, sometimes, to diagnose a disease than it is to cure it, likewise it would be a much easier task to explain how the baneful effects of heredity might be averted than it is to outline their modification or cure.

All transmitted disorders are the result either of the wilful and conscious or of the ignorant and consequently innocent violation of the laws which govern our being. Consequently, in order to overcome the penalty, we need for the wilful violation the constant, persistent exercise of will-power, and for the ignorant violation we need education and proper surroundings, and for both scientific medication of the body.

The first thing necessary is to give the new-born babe all the advantages which the Creator has intended it should enjoy, all the benefits of proper environment, all that comes from a strict observance of the laws of hygiene and dietetics; the use of sunshine, pure air and water. And as the child grows to

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the years of accountability it must be taught the laws of health; be taught what to cultivate and what to avoid; be informed what particular rules of living it must observe in order to overcome hereditary tendency and weakness.

The homœopathic physician has grand opportunities to demonstrate the efficacy of "similia" in the modification and cure of transmitted disease. I will not attempt to enumerate remedies, but suffice it to say that all who have had experience will attest that our system of therapeutics, prescribed according to "similia similibus curantur," is far superior to anything that has been employed in the healing art.

In conclusion, there are three great factors to be employed in the restoration from inherited disorders. First, a thorough education, and especially that kind of education which shall teach the child and youth to "know thyself."

Second, scientific medication of the body; and, third, the potent influence of a pure, godly life, which will impart strength and guidance to every other agency that may be employed.

DISCUSSION.

Dr. Z. T. Miller: I consider the subject of this paper one of the most important in medicine from the fact that we meet so many who are handicapped in such a miserable manner by heredity. They should always command our first and most careful consideration. I consider it more important than any other field for investigation in medicine, and any physician who can overcome these hereditary tendencies of childhood becomes a ministering angel to the public at large. Heredity was forcibly illustrated in a child I saw yesterday. This poor little thing was subject to all the ills to which flesh is heir, and when I informed the mother that she was partly responsible for the child's condition she became very much astonished and indignant. I told her that the course of treatment for improvement would cover a long period of time, and that if she expected the child to improve in a few days she would be disappointed; that it should be her end and aim to overcome all these hereditary tendencies exhibited in her child by the utmost perseverance and exercise of patience and will-power. This question has

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been brought to the notice of this Society many times, and I have never heard it fully discussed, but I believe there is a way to make tolerable the life of a young child thus handicapped and to have it grow up in a comparatively healthy state. I believe it can be made a useful citizen by the continuous application of similia similibus curantur, and if every homœopathic physician will apply this law conscientiously he cannot but get good results. He will be rewarded by seeing some of the finest manifestations of the operation of the law of similia—more so than in any other branch of medicine.

CASES OF TUBERCULAR MENINGITIS CURED WITH IODOFORM.

W. J. MARTIN, M.D., PITTSBURG, PA.

About two years ago I had under treatment a child aged between one and two years who had been sick a week or more with some ailment exhibiting a great variety of symptoms. At times the trouble would appear to be gastric, again cerebral, then as though due to dentition; there was always more or less fever, restlessness and sleeplessness. This was the first illness the child had ever had. The family history was good, no taint of any kind on either the paternal or maternal side, the other children of the family, three in number, all living and well. I called in consultation one of our men whom I consider has no superior as a diagnostician. We went over the case carefully and thoroughly, but he could not agree with me in my opinion that the case was one of tubercular meningitis. It did not, at the time he saw it, seem sick enough. The case went from bad to worse, and died. Then the doctor agreed with me that it had been a case of tubercular meningitis. If it had recovered, he would have adhered to his opinion that it was not and never had been tubercular meningitis.

So it may be with my friends here; when I report such a case as recovering under iodoform, you may question whether or

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not it was really tubercular meningitis. And well you may, for it is written in our most authoritative text-books that the disease is universally acknowledged to be always fatal, and cases of supposed tubercular meningitis making good recoveries are looked upon as examples of diagnostic errors. But (to quote Raue), "Is the disease always fatal?"

"Because there are no infallible means to distinguish during life between it and simple meningitis, those cases which have recovered and were claimed to be tubercular meningitis are simply set down as errors in diagnosis; the real proof—post-mortem—is wanting; and therefore as, in all cases which came under the hands of these physicians, the post-mortem proved their diagnosis correct, they concluded that all other cases must likewise be fatal. Against this conclusion I allow myself to modestly protest. Might not a different treatment prevent post-mortem examination? And are all tubercular affections necessarily fatal? I have lost cases of tubercular meningitis, to be sure, but I believe that I also, as well as others, have cured some. The prognosis is bad, that is true." And the reporting of a case cured may help to cure others.

My attention was first called to the subject of my paper by reading in the *North American Journal of Homœopathy* for February, 1896, an article entitled "Iodoform in Tubercular Meningitis," by Wm. S. Miner, M.D., of New York City, who, I am very sorry to say,—for I knew him well,—died of pneumonia a few days after his paper was published. His cases are described very minutely, and are very interesting, and I do not see how any fair-minded person could for a moment question that two of the three cases, all of which recovered perfectly, were tubercular meningitis. In these cases the iodoform was given by inunction, an ointment of iodoform and vaseline, one drachm to the ounce, being used, about one drachm of this being very thoroughly rubbed into the shaven scalp twice a day. Iodoform, in the sixth and second decimal triturations, a dose every two hours, was also given, and he thought he had the best results from the inunction.

Dr. Martel, in the *Revue Internationale*, reports seven cases cured by this method. He used an ointment of iodoform ʒiii to

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℥ii, a half drachm of which was rubbed into the scalp twice a day.

In his work on the *Practice of Medicine*, our distinguished confrère, Dr. Goodno, says that "among the remedies for tubercular meningitis iodoform stands at the head;" that "it has produced symptoms indistinguishable from meningitis;" that "it is customary with old-school physicians to shave the scalp and apply an iodoform ointment, but that the internal administration of the drug will probably do as much good."

Basing my faith on this, I applied the remedy in the second decimal trituration in the following case: I will not take up time by describing the symptoms present, as you all know how multifarious they may be. I had been attending the child—which was the first and only child in the family, and previously in good health—from the 3d to the 8th of February of this year, prescribing daily belladonna, as I could not see that any other remedy was as well indicated; but the child did not improve one whit. Up to this time, the fifth day of my attendance, I was "at sea" as to diagnosis, though I was becoming suspicious; but now the diagnosis was clearly enough tubercular meningitis. The temperature was 103°, at which it had been standing for three days. Iodoform 2x, four grains in a goblet half full of water, a teaspoonful of this every two hours, was prescribed. This was on the evening of February 8th.

February 9th, A.M.—Temperature, 102°; child a little better.

February 9th, P.M.—Temperature, 102°; child a little better.

February 10th, A.M.—Temperature, 101°; child decidedly better.

February 11th, A.M.—Temperature, 100°; child decidedly better.

February 12th, 13th, 14th and 15th, child decidedly better.

During all this time the iodoform prescription was continued, and on the seventh day after it was commenced the case was dismissed cured and has remained so to this time.

Another case is that of a babe 14 months old, brought to me August 31st the present year; had been sick one week under care of an allopath who changed his prescription every day. The symptoms I noted at the first visit were fever, no sleep, hot

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head. ℞. belladonna. September 2d.—The father reports the child sleeping all the time; he therefore thought it better. ℞. sac. lac. September 4th.—The report is brought that the child still sleeps much, but moves the mouth constantly as though chewing or sucking, bores the head back, and rolls it from side to side. The child has been sick now about twelve days. My suspicions are aroused as to the likelihood of it having tubercular meningitis, but the symptoms being so marked for hellebore, I sent it, with the request that they report in the evening. In the evening I saw the child late, in response to a call sent early, which I did not receive on account of being called out of the city, and found it in most violent convulsions, facial features distorted, eyes squinting, head retracted, neck and back stiff, automatic motion of one arm and leg, and all that kind of thing. There was present a sign which some have claimed to be pathognomonic; that was, when I drew my finger-nail across the child's forehead a red line appeared, and remained a few moments. I prepared iodoform 2x in water, as in preceding case, with instructions to give a teaspoonful every hour. We all expected the child to die before morning, but it did not; on the contrary, when I made my visit the next morning I found that the spasms had almost ceased, the febrile condition was much moderated, and the child could again nurse. The iodoform was continued and the child improved steadily and rapidly, so that in one week from the time of commencing iodoform the child was discharged cured.

SOME THOUGHTS ON THE CHEST DISEASES OF CHILDREN.

MARY A. COOKE, M.D., PHILADELPHIA.

I THINK many members of the profession will sympathize with me when I speak of the difficulty I have at times found of making an exact diagnosis in cases of troubles of the respiratory tract in children, especially in infants; and of the conditions found in *them* I wish especially to speak.

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The physical signs are often not as clearly marked as in older persons, and our auscultation and percussion is often made under difficulties. It is not my purpose to give any description of the anatomy of the chest, or to describe at length the diseases which affect these organs, as this can be found in any text-book on Pædology.

What I wish to do is to mention a few facts which have come to me in the course of my practice, and to report two cases which caused me much anxiety.

Leaving out diseases which primarily affect only the throat, as laryngitis, croup and diphtheria, etc., of which it is not my purpose to speak at this time, we have the following diseases which affect the respiratory tract, and are accompanied with cough, fever, etc.: tracheitis, bronchitis, bronchopneumonia, catarrhal pneumonia or capillary bronchitis, pleurisy, phthisis pulmonalis, with some others more rare.

As I stated, I often find difficulty in making an exact diagnosis, and am many times in doubt as to the prognosis, even in seemingly straight cases—in children the temperature rises so rapidly and so high, many times from very slight disturbance. Some children show symptoms of a spasmodic nature very readily, so that a child often appears to be very sick from very slight cause, and its recovery is often correspondingly rapid. Of course the thermometer is a great help in diagnosis, and high temperature of long duration is grave. The prognosis which the anxious mother urges us to give is often not clear at our first visit. I have frequently been called to a case which presents symptoms as follows: The child is feverish, cross, thirsty, often with flushed face, restlessness, cough, slight increase of respiration. The babe oftens cries after coughing, showing the cough is painful to him. A good deal of rattling of mucus, which symptom alarms the mother, who fears pneumonia, membranous croup, or some other dread disease. The thermometer shows but little elevation of temperature. Inspection of the throat reveals nothing but a slight reddening of the fauces, no swelling or exudate. The babe does not smile or play as usual, but at the same time we do not have the facial expression of a very sick child. Only the larger bron-

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chial tubes, possibly only the trachea, may be involved. Applying the ear to the chest, we hear the loud râles are confined entirely to the upper part of the chest, or rather cervical region. Cases of this kind usually rapidly yield to appropriate treatment, and yet I feel it to be best to use caution in giving the diagnosis. Those in charge of the child should be charged not to let it be exposed in any way so as to run the risk of taking more cold. Sometimes these comparatively easy cases are just the ones which bring us most credit. Unfortunately, however, all do not yield as readily.

Some cases at the onset present graver symptoms, but some of the apparently simple ones do not convalesce as soon as we expect. The more severe cases in the beginning have perhaps for two or three days been suffering from coryza, a little hoarseness, feverishness at night, and other symptoms of a cold, but nothing to cause the parent anxiety.

Often, suddenly, things take a turn for the worse. The temperature runs up to 102° or 103°, may even reach 104° or 105°; pulse rapid, child restless, or sometimes, when fever runs high, seems stupid, and in some cases twitching of limbs, especially during sleep, the foreshadowing of convulsions. Cough troublesome, at times very distressing, at first dry, but later on râles are heard, almost all over the chest; respiration increased, at times very rapid. Appetite poor; often no food will be taken, but patient is generally thirsty. Perhaps the cough is so severe as to induce attacks of vomiting. If the child is at the breast it will often refuse to nurse, seeming not to be able to breathe sufficiently well to maintain the act of suction. Bowels constipated in some cases, in others diarrhœa. Often the stools contain much mucus. In young children, of course, we do not have any expectoration to guide us in determining the nature of the trouble.

Some of these cases go on to bronchopneumonia, catarrhal pneumonia or capillary bronchitis. I think often we are unable to say just when a case ceases to be bronchitis and becomes more serious. Of course, we have signs of the inflammation of lung tissue, and if capillary bronchitis has developed. Dr. Snader tells that the subcrepitant râle is diagnostic of the involvement

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of the small tubes; we also find cyanosis, rapid respiration, quick pulse, and the child is unable to maintain a recumbent position. When this condition of our patient presents itself our prognosis is grave, though not necessarily hopeless.

Croupous or lobar pneumonia does not differ much in its symptoms from that disease in older people, usually sudden in its onset, and often terminating by crisis. In young children, however, we rarely see the rust-colored sputum. The initial chill is often replaced by a convulsion. The pulse-rate of one and one-half to twice respiration-rate is characteristic. Respiration is sighing.

Pleurisy has great pain from breathing. Patient attempts to prevent all motion of chest-wall. There is great unwillingness to change the position. If we can hear the friction-sounds, they are diagnostic.

Pulmonary tuberculosis is usually not as sudden in its onset, but I think the rapid form more common in children than in adults. Fortunately for us, if the pathology is sometimes obscure, our prescribing does not depend entirely on that, and we can often see good indications for our remedies without determining the exact pathology.

I shall only mention a few of the most prominent in chest diseases. Acon., bell., bry., ferrum phos., ipecac, hepar sulph., mercurius, nux vom., phos., puls. and tartar emetic all have their sphere of usefulness. Then I wish to speak of ferrum phos. particularly. When I first went into practice I was brought into contact with one of our older physicians, a woman, who had then been practicing for more than thirty years and had been particularly successful among children. She had studied and used Schüssler's tissue remedies extensively and was enthusiastic in their praise. She called my attention to the usefulness of ferrum phos. in bronchial troubles of children. Her indications for its use were conditions in which aconite seemed indicated, but considered its use could be continued longer than aconite with benefit. There is thirst, fever, restlessness, cough, expression of pain in chest, with increased rapidity of pulse and respiration. I have always kept in mind the advice I received, and have frequently prescribed this drug,

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often with great benefit. Most of our text-books give under the respiratory symptoms of this drug expectoration of bright, red blood. This symptom I have never met with in children. Tartar emetic was another remedy strongly recommended by the same doctor. You all know one very prominent indication is much rattling of mucus, but none expectorated, and this condition is so often present. This drug follows well in cases when ferrum phos. is indicated in the earlier stages. Ammonium carb., ipecac and hepar sulph. are drugs which also have prominently the coarse râles in bronchial tubes. Bryonia is an unfailing friend when soreness and disinclination to be moved and great thirst are present. Bell. has threatening of cerebral trouble. Kali carb. and kali bichromicum are both useful, the stringy expectorations of the latter being particularly characteristic.

With regard to local treatment, many people seem to think some application must be made to the chest, and on my first visit I have often found various things have been used—lard, camphorated oil, tar, fat pork or bacon, mustard, turpentine, and a host of other things.

Many physicians have a great fondness for the flaxseed poultice, but I think it often is too heavy and very apt to be improperly applied. When moist applications are needed, and there are conditions in which they seem to give rapid relief, I think nothing can excel towels wrung out of hot water and covered with oiled silk. These, however, require close attention, so as to change as soon as at all cool, and the flaxseed has the advantage of retaining the heat longer. All moist applications require great care afterwards to prevent the patient taking fresh cold.

In conclusion, I will briefly report two cases which have come under my care the past year.

Edward G., 3 months old, had been sick and under the care of an old-school physician for several weeks previous to my being sent for. The change was made because the parents thought his medicines too strong for the baby. The mother said he had called the case pneumonia. There had been convulsions at the onset, but I did not learn anything very accurately

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about the course of the disease. The baby had been healthy when born, and the family history was good, so far as I was able to ascertain. When I first saw him he was very pale, rather emaciated. He took food tolerably well, but bowels very loose, and he was having a number of greenish stools each day. The cough was persistent and annoying, so much so that he could only sleep a few minutes at a time. Râles were heard all over the chest, but most on left side. There was on this side slight dulness on percussion. He generally assumed the dorsal decubitus. He usually took the right breast well, but often refused the left, as he seemed unable to remain long enough on the left side. Some days, however, he seemed too weak to draw the breast, and even to swallow what was put in his mouth with a spoon. The highest temperature for some days ranged from 100° to 102°, and at times would drop to normal. The cough was at first hard and dry, but later became looser. There was occasional vomiting, principally of mucus; at times sweating took place.

I gave sulph. followed by phos., and later on puls., and still later on tartar emetic. The bowels became much more natural in their action and the cough several times improved much; but the relief was not permanent, though he gained in some ways. He had the disadvantage of some extremely hot weather at this time, which weakened him much. I tried to have his surroundings made as hygienic as possible and had him spend part of each pleasant day in the air, which always seemed to revive him. I had him bathed with olive oil. Administered a small amount of cod-liver oil internally. I had him under my care about a month. Two or three times he seemed really much improved, and then cough would return with rise of temperature. One feature of this case was, that the respiration was by no means very rapid. He did not gain any flesh. During any increase of fever there was more dulness on left side. He finally died rather suddenly, of exhaustion, as far as I could ascertain. The weather was very warm and he seemed just to grow weaker. Was this a case of repeated attacks of catarrhal pneumonia, or was it infantile phthisis? My opinion inclines to the former, but the symptoms were rather indefinite,

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to my mind. I did not find any evidence of abscess of lung, though I thought of that as one of the possible causes of trouble, and it seemed as though the temperature would have run higher. The pulse-rate was a good deal increased, but thought the respiration hardly enough increased for pneumonia. I obtained no evidence of the heart being affected, other than it partook of the general weakness of the system.

The other case I wish to speak of was a baby, who showed symptoms of bronchial trouble from his birth. His mother was far from well during her pregnancy, and suffered from a severe cough most of that time. She had frequent attacks of faintness, and through all worked much harder than she should have done. The child was born in March, 1895. The respiration was always accompanied with coarse mucous râles, and he had slight cough. He grew well during the warm weather, and the râles nearly disappeared, though there was a little cough, which increased as the cool weather came, and the râles were increased again.

During February he had an acute attack of bronchopneumonia, and was sick for weeks. Sometimes better, and then worse. Seemed to take fresh cold, though every care was taken of him. He was not weaned, but as the milk did not seem at all rich, I had him fed a little and weaned before warm weather set in. It was hard before he was weaned to get him to take food. Once during his illness he had decided dulness on left side of chest, while the temperature, which had been only slightly elevated, rose to 102°. The cough was very persistent. These alarming symptoms soon subsided, but it was weeks before he lost the cough. During the summer the trouble had nearly disappeared, though now the heat would bring a return of the old symptoms. In the course of the months I had him under my care I tried several different remedies, but found bell. and bry. in the beginning, and hepar sulph. later on, very useful. Calcarea carb. also seemed to do him good. His dentition was slow, and there was much perspiration about the head. The last time I heard from him he was pretty well, but I am wondering if returning cold weather would bring a return of the trouble.

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THE MOSAIC RITE OF CIRCUMCISION; A PLEA FOR ITS PERFORMANCE DURING CHILDHOOD.

BY S. G. A. BROWN, M.D., SHIPPENSBURG.

CIRCUMCISION as a religious rite dates its origin from the days of Abraham. All authentic evidence points to him as being the first to perform the operation, having performed it upon himself, his son and his servants. Mohammed himself decreed that "circumcision is an ordinance for men and honorable in women." No hygienic or prophylactic importance was attached to the measure, it being simply an agreement between the Divine Being and the Hebrews. "This is my covenant, which ye shall keep between me and you, and thy seed after thee; every man-child among you shall be circumcised." There are those who assert that circumcision as a rite was instituted prior to the time of Abraham, B.C. 1941, but their claims are based wholly upon mythological data.

But why attach so great importance to this appendage? Is it not a physiological appurtenance? If not, why not? What are the dangers that may arise from its presence? Man in his primitive state was provided by nature with this sheath (prepuce) in order to protect the procreative organs from danger and harm, as he, like the animals by which he was surrounded, was attired in nature's garb, being exposed to the bites of insects, the prick of thorny briars, etc. But evolution, environment and civilization have placed man in such a position that he has no further use for this curious relic of a long-past barbaric age.

Why this outlaw of humanity has not received further attention from the fraternity at the present day than it has is a question with the writer. Perhaps delicacy of sentiment is the solution to this enigma. Were we to observe more plain talk, without apologies for doing so, and refrain from rhetorical phraseology and figurative vaunting, humanity, both male and female, would undoubtedly be far better off, mentally, morally and physically.

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All physicians are not agreed as to whether circumcision in childhood is the proper course to pursue, but surely if the matter were investigated thoroughly and with an unbiassed mind, it would stand out as a self-evident fact that much good can be accomplished toward the preservation of health in our children and the increase in their longevity. The Jews, who perform this operation on the eighth day after birth, are, from actual observations, known to be exempt from many diseases which afflict other races. Their children are hardy, and grow up to manhood and womanhood strangers to disease, perfect in body, sound in mind, and with a morality above condemnation. It is rare that they figure in silly crimes, police or divorce courts. That an appendage like the prepuce, which, under various conditions, as phimosis, short frænum or preputial adhesions, is the leading factor in the production of enuresis, dysuria, impotence, calculi, cancer, syphilis, phthisis or various other reflex neuroses, can be considered as a natural physiological appendage, is absurd in the extreme.

In order to render the rising generation healthy, mentally, morally and physically, we must pay attention to this redundant tissue, and advise its early removal. Fully three-fourths of all male babies have abnormal prepuces. Prof. E. H. Pratt says: "A perfectly-formed foreskin in the relaxed state of the organ extends no further than the point of the glans penis. It is free from all adhesions to the glans and corona, and exercises no degree of constriction on the glans itself, and when retracted shows no tendency whatever to pinch the penis."

Let us for a moment consider some of the reflex lesions produced by this redundant, constricting tissue. The loose, pendulous prepuce, or its reflected inner fold back of the corona, or the loose folds about the frænum, furnish admirable soil for the syphilitic virus to germinate in, and it is a candid fact these are the parts usually primarily affected with syphilitic sores. If the prepuce be absent, or if the skin of the glans penis becomes almost non-absorbent by its constant exposure, there is not the tendency to syphilitic inoculation which we would have otherwise. One of our prominent authorities has said that "syphilis has caused more families to become extinct than any ordinary plague, black death, or cholera epidemic." This being

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undoubtedly true, it is nothing short of criminal if we do not employ all the prophylactic measures at hand to wipe out this vagrant disease.

Then, too, the prepuce is an important factor in the production of phthisis. This can be proven by the immunity of the Jewish race from tubercular affections; also the fact that there is a relation existing between a syphilitic taint and a phthisical tendency. The sensitive and absorbing covering of the uncircumcised organ presents a favorable medium for the transmission of the poison from one system to another. What an untold amount of suffering might be prevented by turning our attention to this source of infection in childhood and early youth!

The unconstricted glans in babyhood, boyhood or manhood is rather short and abrupt, the meatus being found on the smooth, rounded front, the corona being prominent and well-developed. When phimosis exists, how different its anatomical appearance! The sebaceous matter that collects about the corona and back of it cannot escape because of the constricting prepuce—and I have seen this in an infant six months old—and the irritation produced on the surface of the glans and the adjacent mucous lining of the prepuce ends in a thickening of the latter; and thus in time we have a thick, undulating, adherent prepuce, with all its baneful concomitants. In such cases, and their number is legion, we have a conical, elongated, cyanosed and hyperæsthetic glans, with a meatus congested and hypertrophied, the corona being undeveloped. This, in turn, by interfering with the outward flow of the seminal fluid, creates impotence, and procreation becomes a probability.

It is not the immediate danger only with which we have to deal in these cases, but the future or remote effects must be taken into consideration also. Corpulent persons with a long prepuce are especially prone to become affected with phimosis as they advance in years, the preputial opening becoming more and more constricted as the size of the erectile tissues of the organs is gradually but surely diminished. Untold misery and suffering are the result.

The elongated prepuce often plays an important part in enuresis. Children who pass their second year and are unable to control the vesical sphincter may be said to be suffering with

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enuresis. This is a very persistent condition, annoying to the mother, mortifying and humiliating to the little sufferer. The irritation from preputial adhesions or the extreme narrowness of the preputial orifice is not infrequently the cause of this trouble. The irritating urine, in passing over the sensitive mucous lining of the prepuce, may create untold suffering and possibly death. It is only a few decades ago that innocent children were scolded and punished when afflicted with nocturnal enuresis. Their irritability, carelessness, moroseness and stupidity were attributed to wilful obstinacy, and they were punished accordingly. In most instances these troubles can be traced to preputial irritation, the child having no control over them whatever.

Next, an elongated prepuce, especially a congenital phimosis having a small aperture, may produce dysuria. The inability to evacuate effectually the contents of the bladder, because of this existing obstruction, produces reflexly painful micturition and probably retention of urine.

Where a chronic inflammation exists over any length of time, due to phimosis or preputial adhesions (or even a balanitis itself), cancer may intervene. This is not an idle theory but a clinical fact. The choked blood-vessels, the chronic inflammation, the constant irritation to the delicate mucous membrane, all tend toward ingrafting this terrible disease upon the innocent, unsuspecting victim. The prepuce is usually alone affected, although the glans sympathizes at times with it. Herpes perputialis is another complication. It behooves us, therefore, as physicians, that we advise, yea, insist upon, an early removal of the redundant mass, especially where phimosis exists, or where frequent attacks of balanoposthitis have been exhibited. Furthermore, children having this pathological appendage, if permitted to grow up uncircumcised, are subjects of many distressing and complicating annoyances, even in other diseases. The thickened, redundant prepuce has on more than one occasion necessitated the use of a catheter during the course of a typhoid or some other continued fever. Then follows prostatic trouble.

Many chronic and apparently obscure affections are induced

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or greatly aggravated by a phimosis. The writer would beg to submit a few cases that have been of unusual interest to him.

CASE I.—Infant, æt. 8 months; mother said did nothing but cry from his birth; otherwise he had been perfectly healthy. Four weeks previous to my being called, he was attacked with a painless non-exhausting diarrhœa which the attending physician could not control; crying continued. Upon examining the case I found nothing unusual save a congenital phimosis. Notwithstanding I prescribed carefully I could not cure the diarrhœa. Child was nourished at the maternal fount. Having received consent of parents operated on prepuce; result, rapid healing; diarrhœa immediately cured; no more crying.

CASE II.—Baby, æt. 10 months; had eczema for last six months. Baffled all internal and external medicinal treatment. Was extremely nervous, with twitching of the right arm and right leg. Upon examination found an elongated, leathery, redundant prepuce, completely adherent to the glans, with an opening so small as scarcely to admit the end of my groove director. Operated promptly, tearing away the adhesions. Result, nervousness with twitching immediately cured; eczema well in ten days without further medication.

Thus I might cite other cases, but these will suffice. What we have said concerning circumcision of the male holds good in the case of a female also, except that the hood is rarely amputated, the adhesions being merely broken up, the same beneficial results being observed. I would cite but one case, that of a little girl aged eight years, who was subject to periodical convulsions from her birth, said convulsions being permanently cured after an adherent prepuce had been loosened. Preputial irritation in many cases is the direct or indirect cause of sphincterismus; hemorrhoids, fissures, etc., following in the wake. Phimosis is a cause of hernia in children. One of our prominent surgeons found that in "fifty consecutive cases of congenital phimosis, thirty-one had hernia," not one of the herniæ being congenital.

The operation that I find satisfactory for the removal of this redundant tissue is somewhat as follows: Draw the prepuce well forward, after having first marked with an aniline pencil

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that portion to be amputated, grasp it with a pair of phimosis forceps, being careful not to include the tip of the glans, and cut off the redundant tissue as previously marked. The cutaneous sheath is then allowed to retract, and the mucous membrane is slit up over the dorsum of the glans to the corona; the sides are then trimmed off, leaving the frænum undisturbed, the sutures being then inserted. I prefer horsehair rendered antiseptic to any other suture. It is firm, and after it has been inserted requires no further attention. It either becomes absorbed, or eats its way through, the parts healing after. Of course, it is understood that the operation should be performed under the usual antiseptic precautions, and that anæsthetics are nearly always used. I prefer chloroform for children and injections of cocaine or eucaine in adults. Hemorrhage is nearly always slight and needs but little attention.

Such, in short, is a brief description of one method of performing the operation. I might describe to you other methods, as that of Prof. Pratt, but the scope of this paper deals with the plea for its necessity only. Shall we, as professors of healing, plod on in our daily course unmindful of the cries of distress and misery around and about us? If this paper do but arouse a little earnest thought within this learned body, its mission will have been accomplished, its writer gratified, and suffering humanity undoubtedly greatly benefited in future years.

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ERYSIPELAS IN INFANCY.

JULIA GOULD WAYLAN, M.D., PHILADELPHIA.

THE definition of erysipelas, as given by Dr. Starr in his recent work on *Children's Diseases*, seems to be most comprehensive and satisfactory. He speaks of it as "an acute, specific, contagious, inflammatory disease of the skin and mucous membrane, accompanied by marked general symptoms and characterized by peculiar local lesions at the seat of inoculation, by its tendency to spread, and by the presence in the affected area of a micrococcus that is capable of reproducing the disease in other individuals."

The streptococcus erysipelas is undoubtedly the contagious principle, and is in all probability identical with the streptococcus pyogenes. This micro-organism has been found in the lymphatic vessels and spaces of the skin, subcutaneous cellular tissue, and in the superficial layers of the corium.

The "erysipelas of infancy" has been divided into:

1. Erysipelas of the new-born.
2. Erysipelas of sucklings.

In *erysipelas of the new-born* the mortality is very high. Occurring, as it does, within the first month of the child's life, the power of resistance is very slight, and the vitality of low degree. This disease is apt to occur during an epidemic of puerperal fever.

The localities usually invaded by the infection being the umbilicus and genitals, however, the disease is liable to invade the tissues at any point of abrasion, whether from forceps or vaccination.

The fever at first is said to be slight, later running up to 105° F. The reddening and swelling appear on the parts affected. The infants show symptoms of general sepsis. Vomiting frequently occurs, followed by collapse and almost without exception by death.

The *erysipelas of sucklings* seems to differ little from the dis-

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ease as seen in adults. It has been found to occur either idiopathically or as a result of traumatism.

The stage of incubation lasts, according to most authorities, from three to seven days.

Rotch, in his work on pediatrics, tells us that when the disease occurs in the early months of life its beginning is usually accompanied by cold extremities and collapse. The temperature is raised, and the higher its degree the graver the prognosis. In some cases the disease is ushered in by convulsions.

The efflorescence is similar to that seen on the adult's skin, but naturally differs on account of the more delicate structure of the skin of the infant.

The eruption exhibits certain peculiarities. Extension usually takes place most rapidly in one direction, but not in an even line. The area of redness and swelling is bounded by an abrupt fall to the level of the healthy surface. The eruption is liable to terminate at natural boundaries. When underlying bone is close to the surface the eruption is frequently absent; thus the chin may be spared while the rest of the face is much swollen. Conversely, when the skin is loosely attached the swelling is great, and even gangrene may occur.

Some authors tell us that the face and head are not so commonly attacked in infants as in adults, while others claim that these are the favorite points of attack.

The diagnosis is readily made, because of the sudden onset of constitutional symptoms, rapidly followed by a red, elevated, painful lesion of the skin, the peculiar qualities of the latter, its tendency to spread, and the sharply-defined border.

The most common complications in erysipelas of infants are meningitis and pneumonia.

I have run over the subject of "erysipelas in infancy" thus hastily and cursorily that it might serve as an introduction to the case of a child I had suffering with this disease, whom, I regret to say, died, whether from a *third threatened* attack of this disease or not I shall never know.

I delivered this child, a boy, weighing eight pounds, after a perfectly normal labor, November 28, 1894, and found him a victim of talipes—a marked case.

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At the expiration of eight days, in consultation with an eminent surgeon of another city, the feet were placed in plaster casts. Upon removal of the casts the following day, because of swelling, a discolored spot was observed at the medio-tarsal joint about the size of a dime—evidently caused by a stoppage of the circulation at that point. As this developed into a sore after a day or two, the casts were left off for about two weeks and returned after the wound was entirely healed, being removed two or three times a week.

The child was very tolerant of this treatment and fretted but little.

I vaccinated him January 24, 1895. This occasioned very little disturbance and soon healed, leaving a good mark.

Somewhat later I released the prepuce from the glans penis, circumcision not being necessary. I mention this here, as the question may arise in the minds of some later on, when I come to the more important facts of the case.

March 19, 1895, the child, being then nearly four months old, without the slightest premonition, was seized with a convulsion lasting half an hour. This was followed by convulsive movements continuing about an hour. At the expiration of this time he fell asleep, and upon awakening nursed as usual, and did not seem unduly restless during the night.

The following day he was seized with another convulsion at 10.45 A.M., and thus remained with no intermission until 4.30 P.M., when, after a half hour of great suspense, because of feeble heart's action and retarded respiration, he fell asleep. He awoke about 7 P.M., and seemed to nurse quite naturally. About 1 P.M., during the prolonged convulsion referred to, the casts were removed, being thought of as a possible cause; nothing unnatural about the feet was observed. During the night following a marked redness presented itself about the cicatrix of the wound referrd to, at the medio-tarsal joint. I was not in attendance upon any contagious case during the time I was engaged in endeavoring to correct this deformity.

The erysipelatous eruption extended over the entire foot and leg up to the waist and down the other side of the buttocks and thigh to the knee, where it stopped. The swelling and inflammation were intense.

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The temperature ranged from 102° to 103° F. A.M., and from 103° to 104⅘° P.M., during the course of the attack.

During the first day or two only a small quantity of urine was passed. Later on the bowels were disturbed for the matter of twenty-four hours. However, the child nursed regularly during the entire attack, and with evident relish.

In the course of three weeks the patient seemed to be entirely recovered, with the exception of a manifest nervous starting at sudden noises.

The casts were returned the morning of April 13, 1895. At 1.30 A.M. of April 14, 1895, he was again seized with a convulsion, lasting perhaps a half hour. The casts were removed immediately, and never returned again during the child's life.

Except for a catarrhal cold in the head and bronchial tubes, he seemed quite comfortable until midnight of April 15, 1895, when his nose began to swell and become greatly inflamed.

The day following he was restless, and seemed to suffer with his head and marked lachrymation.

In forty-eight hours after the first evidence of the recurring erysipelas the entire contour of his head was changed, an apparent contraction at the temples and marked bulging over the vertex. Retraction of the head, almost an opisthotonos. The eruption spread over the face, forehead and ears. The meningeal involvement was marked, and the effusion very great. The head was an enormous soft mass. The child screamed considerably at intervals. During April 24th there seemed some improvement in the general condition of the patient, which continued, and two weeks found the little fellow quite himself again, and apparently in full possession of his faculties. The temperature ran about as in the previous attack. Fortunately the child nursed regularly, as before.

November 7, 1895. He seemed a little restless and feverish in the afternoon, but nothing new to attract the special attention of the mother until 6 P.M., when he was again seized with a convulsion. This convulsion was slight in comparison with those from which he had suffered. He seemed to rest fairly well during the night, and was not really sick during the following day—perhaps a little more fretful than was his

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wont. However, toward midnight of November 8th he became more feverish and was seized with a most violent convulsion, accompanied by the shrill hydrocephalic cry. This lasted for nearly four hours, so violent as to shake a large bed upon which he was lying. The convulsion gradually resolved itself into lighter convulsive movements, but with no return of consciousness, until 6 A.M. of November 9, 1895, when he died, apparently from exhaustion.

Whether this was the initial stage of another attack of erysipelas will naturally remain a question in my mind.

DISCUSSION.

DR. WALTER: I would like to suggest how much it has appeared to me that the death of this child, apparently due to erysipelas, was really dependent upon vaccination. Here was a healthy child, in normal condition in the first days of its life, with but little vital resistance, poisoned by a widespread, medically-endorsed procedure. A short time afterwards the poison showed itself in the form of erysipelas, which is repeated and repeated until the patient dies. I have some feeling about this subject for the very reason that I have standing before me this day the perplexing question whether I shall run the risk of the evil results of such a preventive procedure. People are continually urging this question as to vaccination, considering it a means of preventing a disease which may or may not develop. It seems to be in support of the principle which the great Apostle Paul denounced in his "do evil that good may come." If we are to have death from diseases which are directly traceable to impurities and foulness in the blood, the impurity deliberately placed there with a hope that at some future time it may prevent a possible disease, I hold that we are criminally poisoning the pure blood of a healthy child with the foul humors of a diseased beast, and that it is a disgrace to the enlightenment and progress of the nineteenth century that such a state of affairs is allowed to exist.

A. P. BOWIE, M.D.: I would like to ask the doctor the treatment given this child during the attack of erysipelas. It is an excellent paper, and I would like to know what drugs were used in the treatment.

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JULIA GOULD WAYLAN, M.D.: The treatment was purely homœopathic, indicated remedies having been used as they were called for. No external measures were applied, with the exception of rye flour. The drugs used were belladona, helonias, rhus toxicodendron, sulphur and apis.

Z. T. MILLER, M.D.: Do you think that the vaccination of the child had anything to do with the erysipelas?

DR. WAYLAN: Personally, I feel that the trouble was caused by the first surgical treatment. I think they were too anxious to correct the deformity too rapidly.

R. E. TOMLIN, M.D.: I would like to ask if in the correction of the deformity there were any bad results experienced.

DR. WAYLAN: No; but there was an irritation caused by the plaster cast. I should very much like to have the opinion of the members of the Bureau of Surgery on that particular point.

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REPORT OF THE BUREAU OF SURGERY.

A Few Thoughts Concerning Fractures, by William B. Van Lennep, M.D.
Hip Disease, Its Early Diagnosis and Mechanical Treatment, by George W. Roberts, M.D.
Strangulated Hernia and the Murphy Button, by H. L. Northrop, M.D.
Fractures Involving the Elbow-Joint, by Walter Strong, M.D.
A Case of Brain Abscess, by D. P. Maddux, M.D.
Stimulation in Shock and Collapse, by J. W. Hassler, M.D.

A FEW THOUGHTS CONCERNING FRACTURES.

WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

ANY discussion of the subject of fractures may seem superfluous, particularly to surgeons; but these cases are mostly treated by the general practitioner, especially the country doctor. The results of treatment are often far from satisfactory in any hands, as the limb is almost never as perfect in function and shape as before. I do not for a moment wish to be understood to assume any degree of perfection in my knowledge, or a superiority in my results with such cases; fractures are a greater source of anxiety to me, probably, than any form of surgical work coming under my care. How many so-called "sprained wrists" come out stiff, with an, alas, too late but undoubted evidence of unreduced impaction! How many ankles are deformed and impaired through a broadened joint and an unreduced backward luxation of the foot! Such results are due partly to errors in diagnosis, but especially to a lack of knowledge of the lesions and the correct principles of treatment. Without multiplying examples, I think I may be pardoned for occupying the time of this society with a few thoughts concerning fractures.

The symptoms of fracture as ordinarily given in the books are too numerous to remember easily, and the average man

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looks for but one, *i.e.*, crepitus. As a matter of fact, crepitus is rarely necessary to a diagnosis, and the attempt to obtain it usually results in a flagrant violation of the golden rule of treatment, "be gentle."

The symptoms may be divided into two general classes, the subjective and the objective, of each of which there are three:

1. The history, pain, and loss of function.

2. Deformity, abnormal mobility, and recurrence of the deformity after reduction.

In connection with the subjective symptoms, the method of examination is worthy of consideration. By quiet, systematic questioning to bring out the *history*, more than a tentative diagnosis can often be arrived at, to say nothing of quieting the patient's fears and winning a most necessary confidence. The character of the *pain* caused by the sharp ends of a broken bone, as distinguished from that of a luxation, a sprain, or a contusion, are familiar to all of us. The patient, too, may have felt a snap at the time of injury, or may describe the grating of the ends of the bone. *Loss of function*, present with but few exceptions, will also be brought out.

What can be more characteristic than the history of an old woman, a misstep, pain at the hip, or referred down the thigh, or to the knee, and usually complete loss of function. The diagnosis of intracapsular fracture only requires to be verified by looking for eversion of the foot, while the prognosis is settled by the presence or absence of shortening.

Under *deformity* come that of the limb, the local swelling and distortion, the late greenish-yellow ecchymoses, and the variations in length. In recognizing *abnormal mobility*, crepitus may incidentally be found. It is of use only in deep-seated or joint-fractures where a diagnosis cannot otherwise be reached, and is more often to be looked for to prove the approximation of the broken ends during reduction. *Recurrence of the deformity* has but a very limited sphere.

The first step in the physical examination is *inspection*, which will show deformity, both local and of the limb. It is of much more value when supplemented by *comparison* with the other limb or the other side of the body. A positive diagnosis can

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very frequently be arrived at by this alone. Closely allied to it is *mensuration*, by which the comparative length of limbs and the circumference of parts, as well as the relation of the numerous test-lines, are made out.

So far there has been no laying on of hands, no pain caused, and in the vast majority of cases only corroborative evidence is required from *palpation*. Hence this must be intelligent, with a certain object in view, and, above all, *gentle*. Occasionally *percussion* is of value, as, for instance, in fracture of the inaccessible shafts of the fibula.

In considering special fractures, it may be well to take them up in regions, or according to their frequency, rather than in the text-book order.

Colles's fracture is probably one of the most frequently met with. We are taught to associate this injury with the familiar "silver-fork" deformity, which, when present, permits of a positive diagnosis by inspection alone (Fig. 1).

But this deformity is, unfortunately, either wholly or partly absent in that form of fracture at the lower end of the radius, which is far more common than is generally supposed, the impacted fracture, the usual appearance of which is that of a sprain with typical effusion and often even tendon grating (Fig. 11). In the absence of swelling, a bunching-up of the lower end of the radius may be made out; but if we wait for the effusion to be absorbed it is next to impossible to break up the impaction, the leverage on the lower fragment being so small. Hence I have made it a rule in a case of wrist sprain, with or without bone deformity, to etherize the patient and attempt to break up an impaction. If the bone be intact no harm is done, but if an impacted fracture is present deformity and mobility are produced. This fracture is the exception in the treatment of impactions.

A corroborative symptom in the diagnosis is the prominence of the styloid process of the ulna, producing a tendency in the hand to fall to the radial side, and a broadening of the wrist (Fig. 2). This is due to laceration of the radio-ulnar and lateral ligaments. The lesion has a later importance, because fibrous tissue heals more slowly and less firmly than bone, for

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at times such a fracture will unite kindly, and the patient be discharged with an apparently perfect result only to return in a few weeks with a prominent ulnar styloid process and a consequent partial luxation of the wrist. It is but right to protect ourselves by warning patients against such a possibility, and to prevent it by means of a circular band.

Complete, accurate and early reduction of Colles's fracture is the all-important point in the treatment, some surgeons going so far as to advise no dressing, or, at most, a circular roller or adhesive strip. We should aim, besides, to preserve the arch under the radius, to prevent outward luxation of the ulna, and to keep the fingers moving to avoid tendinous adhesions. The Levis perforated tin splint, or the Carr splint, probably accomplishes this better than any other, while the popular Bond splint tends to break the arch down, but, as a matter of economy and universality, plaster-of-Paris splints are just as serviceable (Fig. 3).

Fractures of the clavicle differ from those we have just considered in that function is usually good, no matter what the deformity. The great variety of dressings devised to overcome this deformity prove that no one fills the bill satisfactorily. The displacement, "downward, forward and inward," is so well known that the indications for treatment are clear. Probably the most successful plan is that used in young women who are willing to lie still for a couple of weeks with a stiff pillow under the well shoulder.

As regards ambulant treatment, I must confess to a decided prejudice against the axillary pad as applied in the Fox dressing and all its modifications. I was led to try the posterior figure-eight because it was the only dressing a medical superintendent could keep on his patients in an insane asylum. I have found it of especial value in children, and the first adult on whom I used it, an engineer, was able to drive his locomotive throughout the treatment. This dressing has the disadvantage, to a degree, of the axillary pad, although the pressure can be relieved by carrying the arms from the side. A few weeks ago I was forced to modify the principle of the figure-eight in a fracture of the clavicle in

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which all of the ordinary dressings had failed to overcome the deformity, and in which wounds of the anterior axillary folds precluded the use of the figure-eight. The shoulders were drawn forcibly back until the over-riding was reduced, and held by a broad band of adhesive plaster, extending around from the front of one shoulder, across the back, to the front of the other. Fearing some drooping, I supplemented this with a sling of the elbow (Fig. 4).

In examining the shoulder, after the subjective symptoms are obtained, comparative inspection is of the greatest value—the hollow from dislocation, the extra joint in fracture at the neck, the sharp edge and depression of fracture of the acromion and dislocation of the scapula, and the positions of the arm in fracture and dislocation all being familiar. Then the comparative length of the arms is sought for by mensuration, and to this is added the comparative circumference of the two shoulders and the external plane of the arms. Lastly, the hands are gently laid on to find whether the head of the humerus is in place and moves with the shaft, whether the arm is abnormally mobile or immobile, and to palpate the clavicle, the acromion, the scapular spine and body and the coracoid process in thin subjects.

For practical purposes the fractures at the upper extremity of the humerus may be considered as the intra- and extra-capsular. The former are obscure joint injuries, fissured, comminuted or impacted, and occur in the old, or are produced by severe direct violence. Joint effusion and inflammation quickly follow and more or less stiffness usually results. The diagnosis has to depend on the history, exclusion, absence of motion in the head if complete, and principally on the recognition of deep-seated crepitus. The treatment is to bind the arm to the side, a sling of the hand, and the ice-bag to the joint.

Fracture of the surgical neck and the adjacent epiphyseal separation of the young, as well as the numerous breaks of the shaft, are readily diagnosed, and the minimum of damage done by the plan of examination already given. They are all treated by the internal angular splint, shoulder-cap or outside moulded splint and a sling. Occasionally adhesive plaster extension is

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necessary, or, better, approximation is obtained by the principle of the Stromeyer pad and Middledorpf's triangle.

Two complications are to be looked for in fracture of the shaft: 1. Laceration of the musculo-spiral nerve or inclusion of the same in the callus, producing the characteristic wrist-drop; and, 2, non-union, which, as is well known, is apt to be progressive, resulting in extensive defects. Both of these may require operative interference: nerve suture or liberation; or, besides the usual measures for non-union, bone transplantation. Fortunately, shortening is not as disabling in the upper as in the lower extremity.

Fracture with dislocation is often a very troublesome injury. It may be a primary lesion or the break may be produced while reducing a dislocation. It usually occurs near the surgical neck, although it may take place within the joint. In the latter case little else can be done than remove the loose fragment sooner or later; in the former the plan has been to get union and reduce the luxation afterwards if the primary attempts fail, to form a false joint, or to exercise the upper fragment. McBurney has suggested an ingenious procedure which he has practised successfully. The upper fragment is exposed, a doubly-curved hook, with a long handle to give leverage, is introduced into a hole bored in the shaft, and the manipulations for the reduction of a dislocation are carried out. (He has since applied his plan to an ancient luxation without fracture, steadying the scapula with a similar hook inserted into its spine.)

Fracture of the neck of the scapula is looked upon as exceedingly rare, but I have not found it so. The symptoms are those of a downward dislocation, the arm, however, being, theoretically, limp at the side, instead of abducted and rigid. Reduction is easily accomplished by simply pushing the arm up or by the usual manipulations for a subglenoid luxation; but the deformity recurs and crepitus is elicited. That recurrence of deformity is not to be looked upon as pathognomonic is shown by some of the consecutive dislocations we meet with. I recall a case of subclavicular luxation which was brought to the subcoracoid position and then reduced by the Kocher

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method. On moving the arm the dislocation recurred, and was only completely reduced by first drawing the head into the axilla and then replacing it. The primary luxation was subglenoid, the secondary subcoracoid, and finally subclavicular. Such journeys are not uncommon. I feel that it is worth while to urge attention to the Kocher method in anterior luxations, and the principles of reduction by manipulation in the downward and very rare backward dislocations, in view of the uncouth means so frequently employed.

The elbow is the peer at least of the shoulder in difficulties and in the number of its injuries; the surgical points being the position of the head of the radius, the inter-condyloid test-line, and mensuration of the arm and forearm.

Transverse fracture of the humerus, and its analogue, the separation of the lower epiphysis in children (Fig. 13) closely resemble backward dislocation of both bones, and some teach that recurrence after reduction is the distinctive point. With a chipped-off coronoid, a luxation, however, recurs. True, they are both reduced on the principle of traction in the direction of the deformity, but a diagnosis ought to be made before manipulations are begun. The relation of the head of the radius to the external epicondyle, and of the olecranon to the inter-condyloid test-line, the shortening of the arm in fracture and of the forearm in dislocation, will serve to distinguish most cases. Retention in either instance is accomplished by the anterior angular splint at first, and later by the internal angular.

Fractures of the internal condyle, aside from entering the joint, owe their importance to their tendency to destroy the carrying power of the arm, producing the well-known gun-stock deformity. They are recognized by obtaining independent mobility or deep crepitus and deformity, the fragment being forward while the ulna is displaced laterally. Considerable discussion has arisen as to whether they should be treated in the flexed or extended position. Personally I prefer a straight splint shaped on the well side to follow the carrying curve. This is turned around and applied to the injured limb with a generous padding opposite the joint to avoid complete exten-

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sion (Fig. 5). In the course of two or three weeks an anterior, or, better, an internal right-angled splint can be substituted. In case of stiffening, the forearm is thus nearly in the ideal position for a stiff elbow.

The same splint, similarly padded, answers very well for fractures of the olecranon, aided, perhaps, by a retentive strip of adhesive plaster. I have on several occasions met with a fracture of the olecranon within the fibrous expansion of the triceps and without, at least, primary displacement. This should be looked for in injuries in this region. If compound or comminuted, fractures of the upper end of the ulna had better be wired.

The same violence that produces a Colles's fracture may fail at this point and splinter the head of the radius against the capitellium humeri. A much more important injury is the subluxation of the head of the radius produced by the common practice of lifting a child across a gutter by the hand; it cries and refuses to use the arm. Attention is not called to the injury, or it is overlooked by the physician. The deformity is slight flexion and pronation, with the head of the radius a little low. Reduction is accomplished by extreme supination, after which the arm is rested on an internal or anterior angular splint.

Fractures of the forearm are readily made out, the subcutaneous ulna and the non-rotating head of the radius, together with comparative mensuration of the bones, being the gentle, objective means of diagnosis. Interosseous callus, destroying pronation and supination is to be feared, and may be prevented by the position midway between the two, that is to say, on an internal angular splint with a straight dorsal one and the thumb pointing upward. Also by using wide splints, which do not allow lateral pressure by the bandage. Interosseous pads and non-elastic or tight dressings are to be avoided on account of the well-known tendency to gangrene in the forearm. This is probably due to the presence of what might be termed an internal splint formed by the two bones and the unyielding interosseous membrane.

Unnecessary though it may seem to some, I will take occasion

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in this connection to deprecate the use of the too frequently applied preliminary bandage. Its only sphere is to support the parts below a splint.

An exception to the above-mentioned position is met with in fractures of the radius above its middle, or above the insertion of the pronator radii teres. The supinators are not resisted, and the upper fragment besides being flexed, is rotated outward. Hence the primary dressing must be an anterior angular splint, the ideal internal angular being substituted later on.

It is worth while to remember that the radius is not only broken higher up than the ulna, but that its head is likely to be dislocated, forward most frequently, in fracture of its fellow.

About the ankle, the most common fractures are Pott's and those associated with sprains, "the sprain fractures." The latter owe their importance to the fact that they are overlooked and treated as sprains, the displacement being left unreduced, and stiffness of the joint, with subsequent eversion or inversion of the foot, resulting. In every case of sprain the malleoli should be carefully examined. If one is found to move, it is accurately "set," inflammation is controlled by the ice-bag, with the foot in a fracture box, and then a plaster cast applied during the balance of the healing.

Gibney has advocated the early or immediate use of adhesive plaster in sprained ankles. From an extended experience, I can most heartily endorse his plan, and have carried it farther by applying it to "sprain fracture." The foot is put up as for a sprain, particular attention being given to the strips over the broken malleolus, so as to hold the fragment in place. A starch or plaster cast is added, this being the only difference from the treatment of a sprain.

As regards Pott's fracture, Stimson has emphasized the resulting lesions, and suggested a valuable method of treatment, based upon an intelligent understanding of the same. The lesions are:

1. A fracture of the fibula two or three inches above the malleolus.

2. A break at the outer side of the lower end of the tibia, or a laceration of the tibio-fibular ligament.

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3. A chipping off of the inner malleolus, or a laceration of the internal lateral ligament.

As a result, the foot is everted and displaced backward. The joint is broadened, both antero-posteriorly through the backward luxation, and laterally through a widening of the tibio-fibular mortice (Figs. 6 and 7).

By means of the Dupuytren splint, which is harsh and apt to make damaging pressure, the eversion is corrected, but the backward displacement is not necessarily overcome; in consequence, flexion of the foot is permanently impaired.

Reduction is accomplished by grasping the leg with one hand, taking the sole of the foot in the palm of the other. The foot is drawn forward and turned inward beyond the normal position. If chipped off, the inner malleolus is manipulated into place, and it is very apt, sooner or later, to break through the skin. The retentive dressings consist of a posterior plaster-of-Paris splint from below the knee to beyond the tips of the toes. This prevents backward displacement. The inversion is held by a similar splint, starting on the dorsum of the foot, running around its outer side, across the sole and up the inner side of the leg to a corresponding height. They are held in place by a few circular turns at the foot, ankle and the upper end. In the course of three weeks a cast can be substituted, which gives the patient more freedom.

In my service at the Hahnemann Hospital and Dispensary, fractures of the upper extremity are almost all treated as out-patients. So crowded are the wards by the large accident material that we keep most fractures below the femur but ten days or two weeks as in-patients. Fractures of the leg are put up in a fracture-box with an ice-bag, and, as soon as the swelling is controlled or the wounds are healed, they are sent out in a cast and on crutches. One or two diagnostic points may be worthy of mention. The subcutaneous tibial crest makes the recognition of solutions of its continuity plainly visible or tangible to a gently palpating finger. Shortening can be recognized by seating the patient in a chair with the legs bare, and comparing the height of the knees (Fig. 8). Loss of function—*i.e.*, power to walk—is not necessarily absent,

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even in fracture of both bones of the leg. Excessive manipulations to make out a coincident break in the fibula should be avoided. Percussion at one end of this bone, with a finger at the other, or pressure at one end to elicit pain at the point of fracture, will often settle the question. In fractures of the tibia a possible luxation of the head of the fibula should be looked for. I know of more than one instance in which this oversight has caused trouble for the physician.

The most frequent fractures about the knee are those of the patella (Fig. 9). The treatment of this lesion has, of late years, excited considerable discussion, and some have tried hard to popularize direct or indirect suture of the bone. In an impartial article, Bull has voiced the sentiment of most conservative surgeons, which is, that, in spite of the improved methods of wound treatment, accidents do occur; that the union obtained is not, as a rule, as strong or any more serviceable than the fibrous union, even of considerable length, resulting from splint treatment, which is certainly the method for the great majority of practitioners. Operation is indicated in compound fracture, in refracture and in bad function from long fibrous union.

The treatment consists of the inclined plane and ice-bag at first, then a removable cast, in which the patient can go about on crutches, up to six weeks, and a posterior splint for six more; some protective apparatus for three months, and care, with gradual restoration of flexion to the end of the year.

I have used Gibney's adhesive treatment considerably and with gratifying results in the sprains of the knee so common among football players nowadays, and have applied the same dressing to fractures of the patella, adding the cast, of course. The use of adhesive plaster, by the way, can be extended to sprains in any part of the body, even to those annoying ones of the back. In these sprains, and particularly in fractures of the patella, the most important point is to prevent atrophy of the quadriceps extensor, some surgeons almost ignoring attempts at union for this.

I cannot leave the subject of the patella without referring to an oft-forgotten principle, simple though it may be, in the re-

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duction of dislocations of this bone, *i.e.*, that it is a part of the quadriceps tendon. I have on several occasions been called to reduce luxations of the patella which had resisted pushing, pulling, twisting, and mauling for hours. By extending the leg and flexing the thigh it has of itself slipped into place.

A much more severe injury is the transverse fracture (rarely an epiphyseal separation) of the femur above the condyles. By the action of the gastrocnemius the lower fragment is apt to make destructive pressure upon the popliteal vessels. In my observation diagnostic manipulations and those directed towards reduction without recognizing the mechanism of the displacement have in several instances resulted in gangrene. Relaxation of the muscle by flexing the leg and the double inclined plane, aided at times by tenotomy of the tendo Achillis, and, above all, gentleness have been successful in my hands.

The presence of longitudinal fracture making a T and entering the joint, or severe inflammation of the adjacent joint, are not infrequent complications, and require that the limb be put as soon as possible into the best position for a stiff knee.

There are two fractures at the hip which are both common and troublesome if not treated properly, the intracapsular, or more correctly, intra-articular, and the extra-capsular or extra-articular. Before considering these, let us recall for a moment the surgical points at the hip: Nelaton's test-line and Bryant's triangle to get the comparative height of the trochanters; the arc of rotation to obtain the comparative length of the femoral necks; mensuration for the comparative length of the two limbs; Allis's test for the rigidity of the fascia lata; and the position of the limb, and particularly of the foot—everted, inverted, fixed.

Intracapsular fracture is at first a partial one according to some, an impaction according to others. In a classical case the diagnosis is made by the history: an aged patient, usually a woman, a slight fall and indirect violence; by the pain at the hip, or more often down the thigh to the knee, frequently associated with muscular spasms; and by more or less loss of function. Inspection shows eversion of the limb; mensuration and the test-lines are practically negative. No other symptoms

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are necessary. Complete fracture, as shown by mensuration, Nelaton's and Bryant's lines, shortened arc of rotation, recurrence of the deformity, etc., indicates that treatment with a view to obtaining union is useless, and that comfort and preservation of life alone should be looked for.

If we do not try to know too much, and if the above treatment is carried out successfully, union of incomplete fracture in my experience has been the rule, and aside from the results of osteophytes and rheumatoid pains, function has been restored.

The same applies in a less degree to extra-capsular fractures. If impacted, as they usually are, and Nature has not splinted the limb in a useless position, her work should be left alone. The history is usually that of a younger patient, a direct and greater violence, localized pain and tenderness and less impairment of function. The trochanter is raised, the arc of rotation somewhat reduced, the limb perhaps slightly shortened, and the foot everted and more or less fixed. Abnormal mobility and crepitus are, of course, unnecessary, and attempts to obtain them dangerous.

In no class of fractures is a systematic and progressive examination, stopping even with a tentative diagnosis rather than do harm, of greater preventive value than in those of the hip. Especially is this true because we are unable to say positively whether the break is inside or outside the joint in any given case.

Just below the hip, in the upper third of the thigh, is a fracture which often comes out badly. We are taught to treat these fractures with a flexed thigh, to raise the lower to the upper fragment, which is acted upon by the psoas and iliacus muscles. The deformity I have been troubled with during union has been a bowing outward, so that I have come to treat them with an inclined plane and an external splint, bringing the thigh down to the bed as soon as possible and continuing the long external splint with a steadying cross-piece at the foot.

Fractures of the femur in children I have treated by the excellent Hamilton splint, vertical suspension in the very young, and in the new-born by bandaging the thigh to the abdomen with anterior and posterior coaptation splints (Ellefsen).

I am frequently asked by recent graduates and practitioners

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to make them out a list of splints necessary for the average emergency. How many of us have been cajoled or browbeaten into buying complete sets of carved, felt, or other splints, which never fit the patients we try them on. The best use I have ever seen for such an armamentarium is that it was put to by a well-known colleague. He arranged and locked them in a plate-glass case in his front office and threw away the key. So, too, with the numerous internal and anterior and other wooden splints which are sold in the instrument shops.. They have to be cut off to fit each case, and are thereafter unfit for any other. As a matter of convenience, as well as economy, I have had made a couple of metal pieces, one a rectangle and the other bent at a right angle, perforated with screw-holes, at a cost of 20 to 30 cents each (Fig. 10).

For a mere trifle any carpenter can make up a lot of thin pine boards, say 3, 2½ and 2 inches wide, and 18, 15, and 12 inches long respectively. The boards are cut to fit the limb and thrown away after union is complete, the metal pieces being used over and over again. With these boards, metal pieces, a few screws, a screw-driver and a small saw, in a cloth "lawyer's bag," we have a complete and inexpensive splint armamentarium.

For instance, two boards of appropriate length held together by a rectangular piece of metal make the ideal internal angular, or, held by a right-angled one, the anterior angular splint (Fig. 10). By sawing one end to the requisite angle and uniting two boards with the straight holder, we can make a splint corresponding to the carrying power of the arm (Fig. 5). So, too, for the lower extremity, we can unite boards with the rectangular holders and fasten another across the lower end with the right-angled pieces, making a Hamilton splint, or unite several boards or bed-slats and attach a steadying cross foot piece in like manner for a long external splint. Short coaptation splints are either made by several of the narrow boards, by incorporating the same in a piece of cloth on the principle of the well-known dish-mat that rolls up, or by pieces of heavy cardboard. The last-named will also serve, as is well known, for the shoulder-cap and chin-trough. Plaster-of-Paris bandages, either prepared fresh or

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kept in hermetically-sealed boxes, will enable us to make all the moulded splints and every kind of cast. There only remain adhesive plaster, roller bandages and handkerchiefs.

I cannot leave the subject of fracture without referring to the treatment of the open or compound. While the general practitioner may decline to operate for an urgent appendicitis, a strangulated hernia, a broken skull, or even an emergency tracheotomy, while he may refuse to set and wire the fragments in a bad compound fracture, he is not excusable if he does not render such first aid to the injured as will prevent wound sepsis and make it possible to transform a compound into a simple fracture.

I well remember a bad compound fracture of the leg in the child of a prominent man in this city, which I was unable to see until the day after the accident. The attending physician had scrupulously disinfected the wounds and their vicinity both mechanically and chemically, and had occluded them with a bichloride dressing kept wet—nothing more. When the father complimented me on the result later on, I explained to him that it would have been impossible but for the intelligent preliminary treatment. And yet how often do ethics oblige surgeons to take the blame for suppuration, necrosis, deformity, and even loss of limb and life, when this very preliminary attention is neglected. In my experience, both in hospital and private practice, the transformation of a compound into a simple fracture has been the rule under such preliminary treatment, and the fragments have usually been even more accurately set and held in place on account of the inspection, direct manipulation and internal splinting with silver wire, made possible by the wound. The details of a conscientious and painstaking antiseptic purification and occlusion are too well known to require repetition here. By such means alone can a complete condition of asepsis be induced in emergency practice.

Within a few months a most valuable aid to the diagnosis and treatment of fractures has been developed in the X-rays, and particularly by the addition of Edison's fluoroscope. While I was enabled to obtain the well-known results in radiography,

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by means of the fluoroscope the apparatus has come to be of daily use in my office. The great drawback to the general adoption of the Roentgen rays is the expense. This I found to be particularly the case in the beginning of the *furore*, when I bought my first outfit. At the present rate of decrease, however, it will not be long before radioscopy will be available to all. The diagnosis of all fractures of the extremities is much facilitated, and, what is of more value, the position of the fragments can be inspected with the fluoroscope after the application of non-metallic splints. Subsequent taking down of the dressings, with its accompanying pain and disturbance, can thus be often avoided. So, too, the approximation of the fragments can be accurately accomplished under the guidance of the eye. Subjoined are a few illustrative radiographs (Figs. 11–14).

I have also observed what was, to me, a new property of the X-rays, a therapeutic one. The pains of periosteal and bone injuries seem to be arrested temporarily, at least, by their action. Whether such results will be permanent or not, time alone can show, but I have enough evidence to satisfy me that the plan is worthy of a more extended trial.

Since this paper was read I have had abundant opportunity to observe some of the trophic changes produced by the X-rays in those who have been in frequent proximity with my outfit. They corroborate the recorded observations, such as blistering, gangrene, or atrophy of the skin, loss of hair in the hand, changes in the finger-nails, disturbances of vision, etc.

FIG. 1 is a Colles's fracture of the left radius, in a young and rather thin subject, taken immediately after the accident and before swelling had set in.

FIG. 2 is also a Colles's fracture, in a powerful man, some hours after the injury, and, therefore, the ulnar styloid process is not as prominent as it was at first. The displacement of the hand to the radial side has not been reduced by the weight of the arm, which is held up by the fingers.

FIG. 3 represents the plaster-of-Paris splints which have been allowed to harden on the limb while the deformities were held reduced. They are made by folding a wet plaster bandage forward and back to the desired length until the requisite thickness is obtained. It will be noted that the hand is carried to the ulnar side and that the arch under the radius is well supported. The padding has been purposely omitted to give a better view of the splints.

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FIG. 4 is the dressing, for fracture of the clavicle, of adhesive strips to pull the shoulder backward and outward, while it is held up by the Moore handkerchief sling, the application of which is readily seen.

FIG. 5 shows the adaptation of the writer's splint, shaped to preserve the "carrying power" of the arm, in a fracture of the internal condyle of the right humerus. The padding and bandage have been omitted for obvious reasons.

FIGS. 6 and 7 were taken just after the admission of a patient to the Hahnemann Hospital, who had sustained a Pott's fracture of the left ankle. In spite of the position of the limb, in Fig. 6, which partially reduced the backward luxation of the foot, the lower anterior edge of the tibia and fibula is still noticeable above the joint. The outward displacement of the foot appears in Fig. 7.

FIG. 8 is the photograph of an old fracture of both bones of the lower third of the left leg. It shows the difference in length between the limbs, obtained by seating the patient in a chair and comparing the height of the two knees. The ankle is broadened and the fibular malleolus is prominent. A well-marked *hallux valgus* and *hammer-toes* can also be seen on the injured side.

FIG. 9 was taken from a fracture of the left patella before effusion had obscured the lesion. The deformity has been intensified by partially flexing the leg.

FIG. 10 shows the writer's metal plates and the internal and anterior angular splints made by applying them to boards which may differ in length and width, according to the patient. Fig. 5 is another application as described.

FIG. 11 cleared up the condition in an obscure, impacted Colles's fracture treated in the orthopædic out-patient department of the Hahnemann Hospital. The skiagraph was taken by an exposure of two minutes with a 6-inch coil supplied by storage batteries.

FIG. 12 was taken with a 10-inch coil, storage battery and three-and-a-half minutes' exposure. The patient, a child of four years, had sustained an epiphyseal separation at the lower end of the humerus, which had presumably been reduced. The splint, padding and bandage were in place, and the diagnosis was readily made with the fluoroscope. The olecranon epiphysis gives the impression of a separation there.

FIG. 13 shows an accurately set fracture of the tibia as seen through the dressings. The posterior perforated, metallic trough throws a distinct shadow. The skiagraph was the result of an hour's exposure, and was taken in March last with a 3-inch coil and the street current.

FIG. 14 enabled us to arrive at a diagnosis in a doubtful injury to the radius with localized pain, but no mobility. An impacted fracture is easily recognized. The skiagraph was taken last April with a 5-inch coil, the street current and 15 minutes' exposure.

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FIG. 1.—Colles's fracture; silver fork deformity.

FIG. 2.—Colles's fracture; prominence of ulnar styloid; radial luxation of hand.

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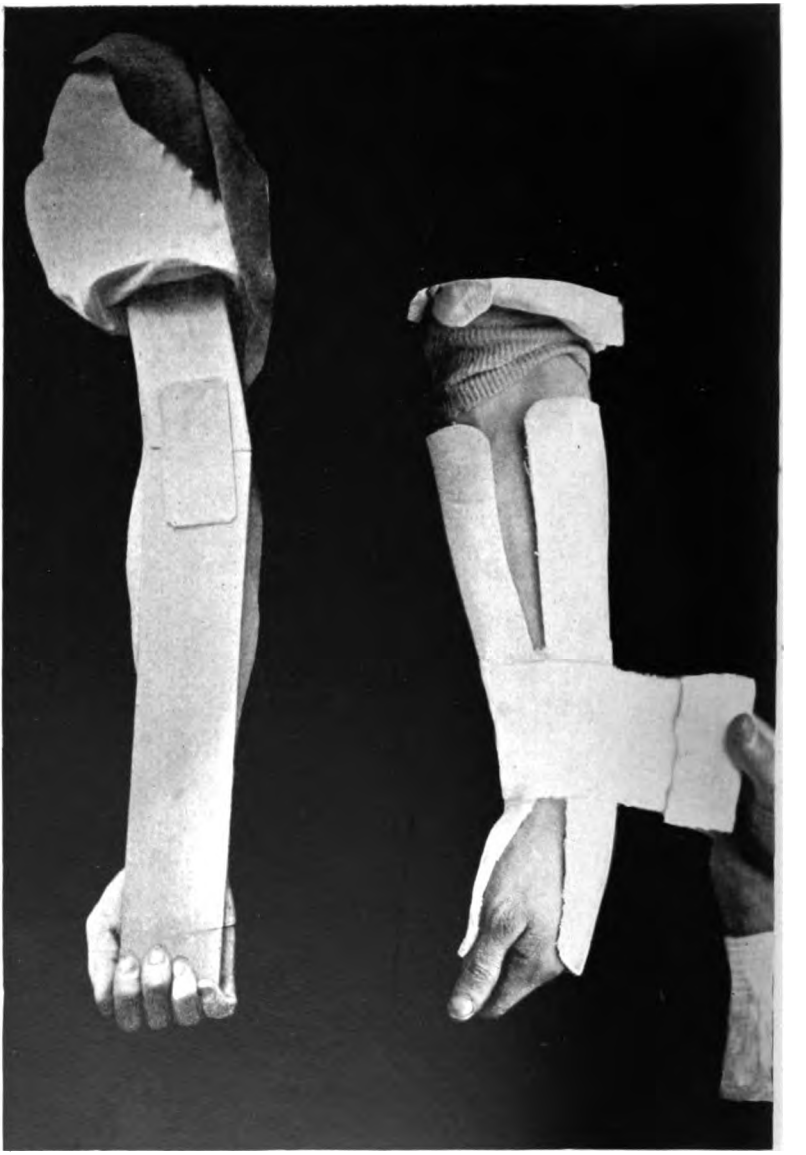

FIG. 5.—Straight anterior splint shaped to preserve "carrying-power" of arm; padding omitted.

FIG. 3.—Colles's fracture; plaster-of-Paris splints; padding omitted.

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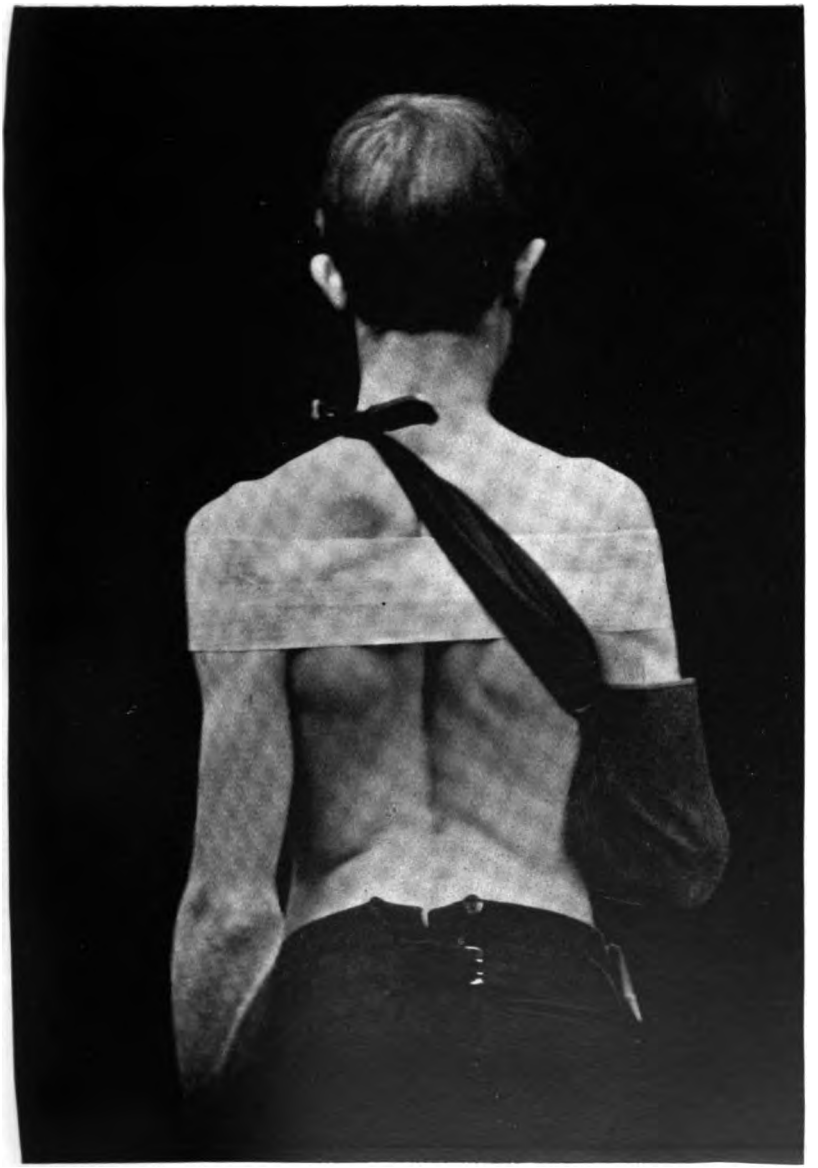

FIG. 4.—Fracture of right clavicle ; adhesive plaster and sling dressing.

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FIG. 6.—Pott's fracture; backward displacement of foot; antero-posterior broadening of ankle.

FIG. 7.—Pott's fracture; eversion of foot; widening of tibio-fibular mortice.

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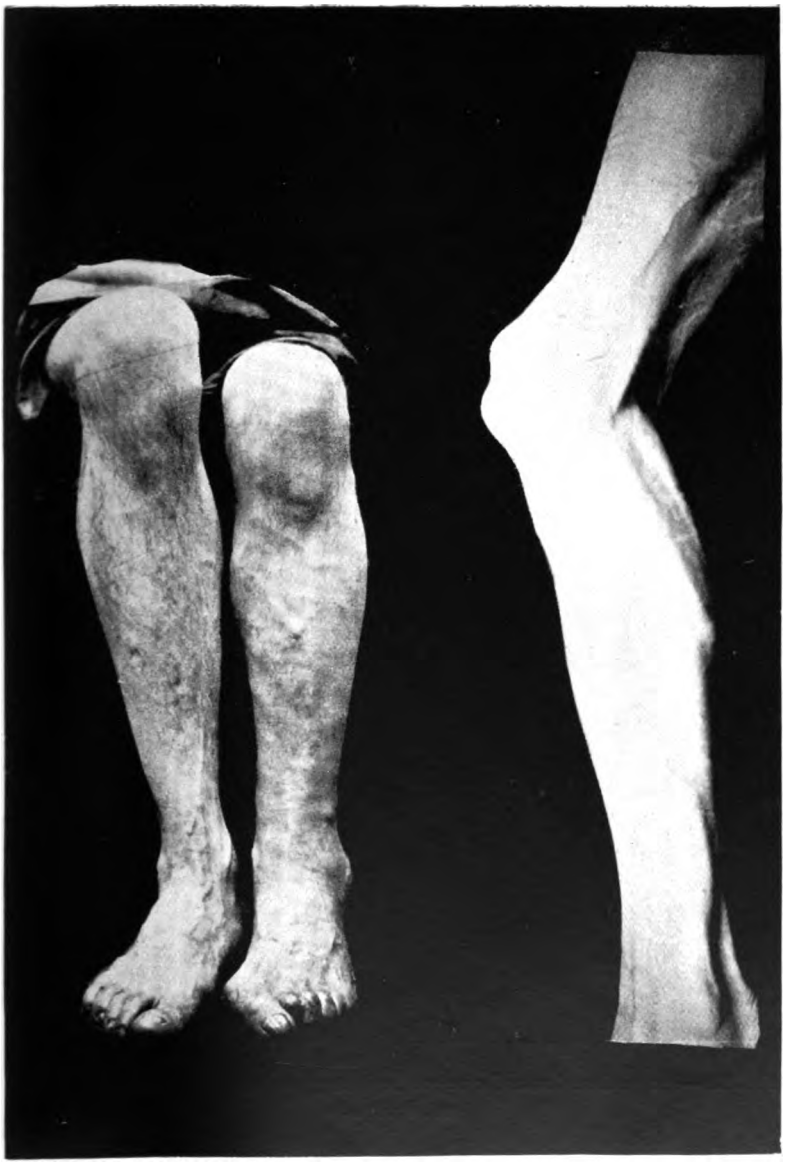

FIG. 8.—Comparative height of knees, to show shortening of leg.

FIG. 9.—Fracture of left patella, showing typical deformity produced by moderate flexion of leg and thigh.

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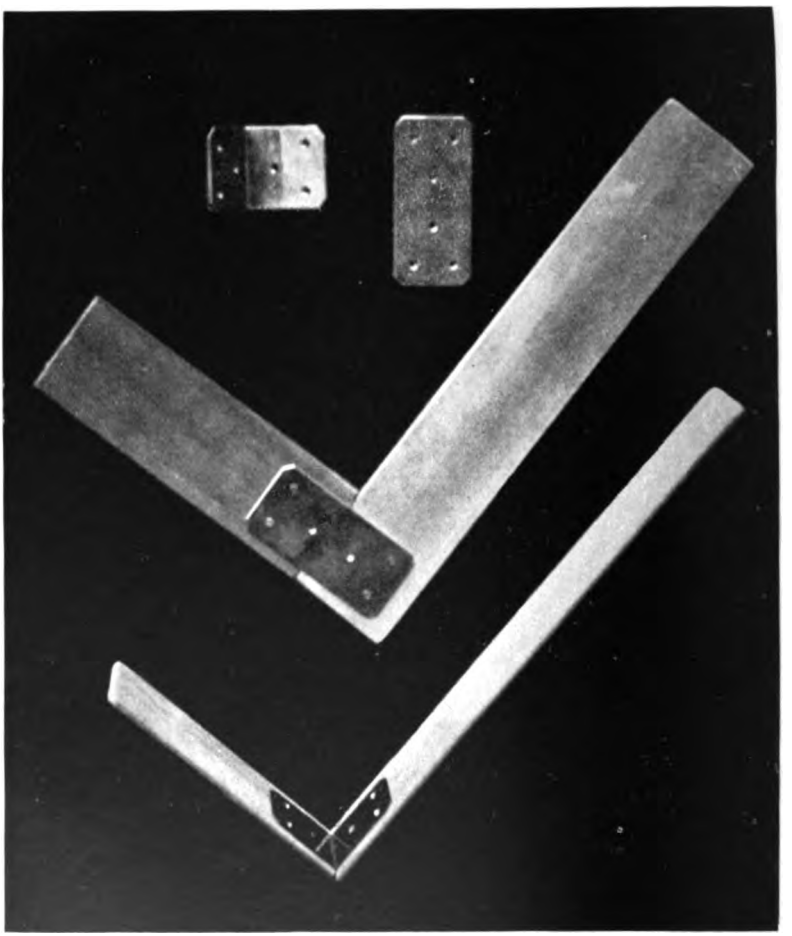

FIG. 10.—Internal and anterior angular splints; rectangular and right-angled metal pieces.

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FIG. 11.—Impacted Colles's fracture.

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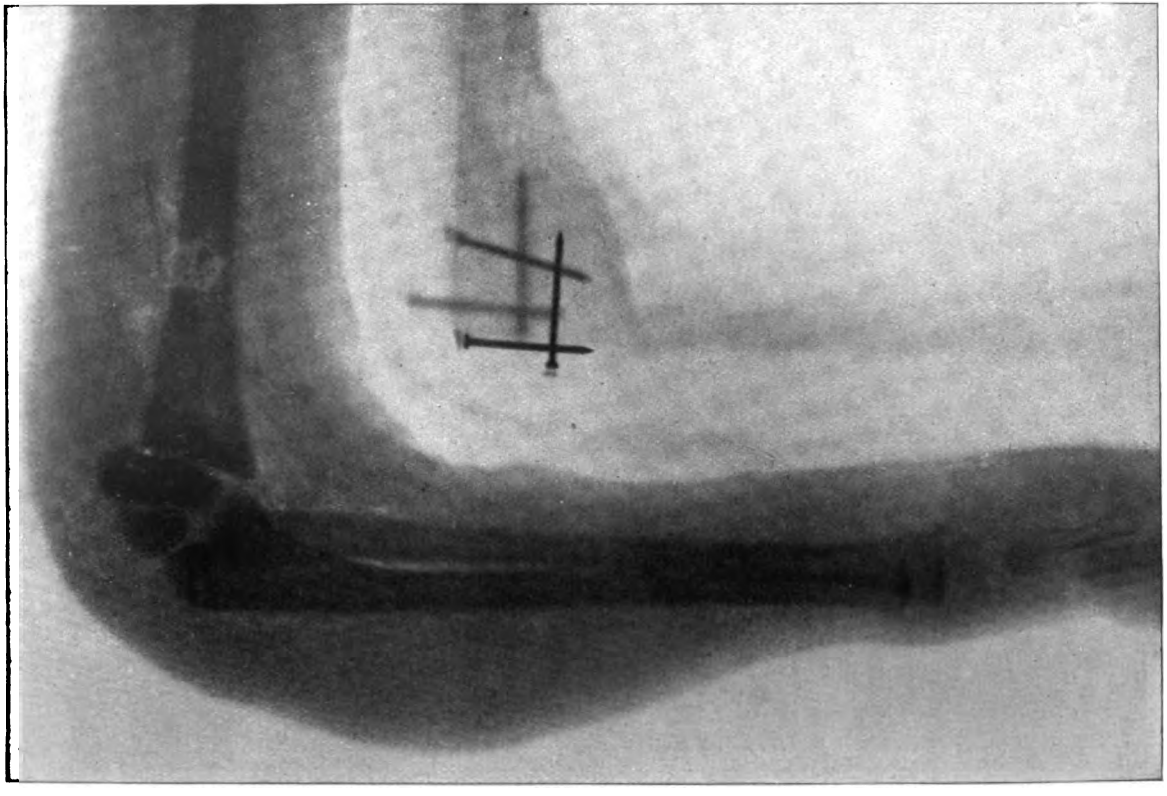

FIG. 12.—Separation of lower humeral epiphysis, as seen through the dressings.

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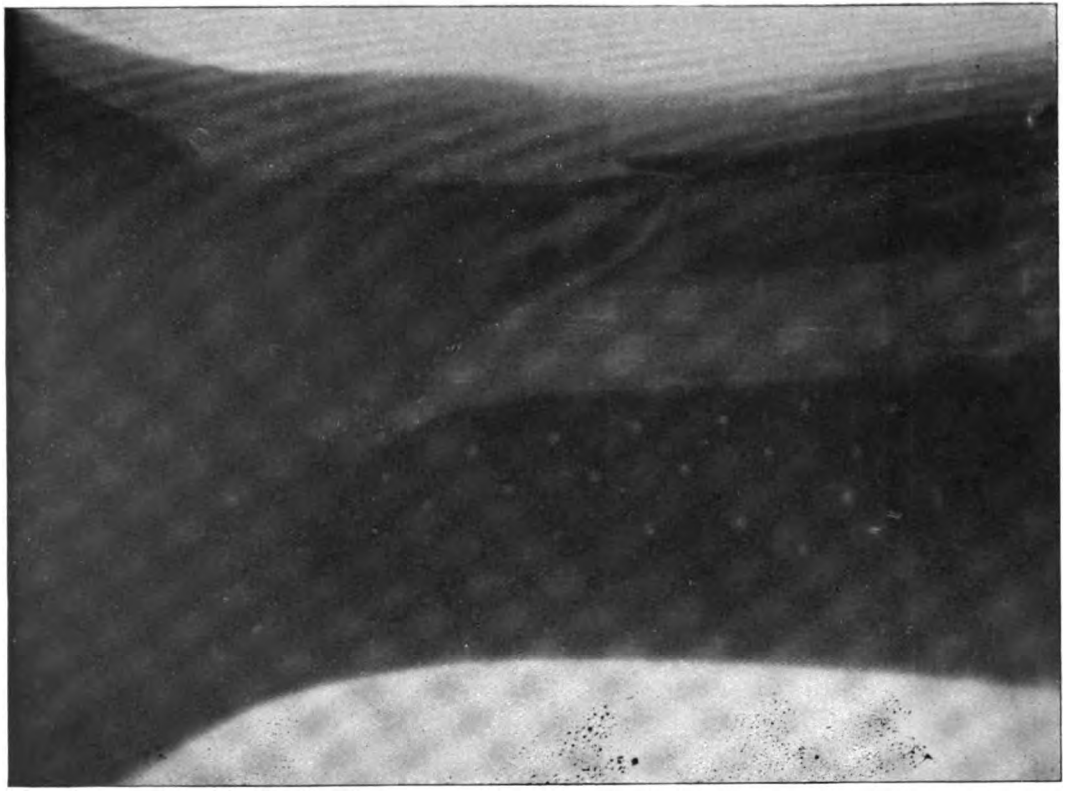

FIG. 13.—Fracture of tibia, reduced and dressed.

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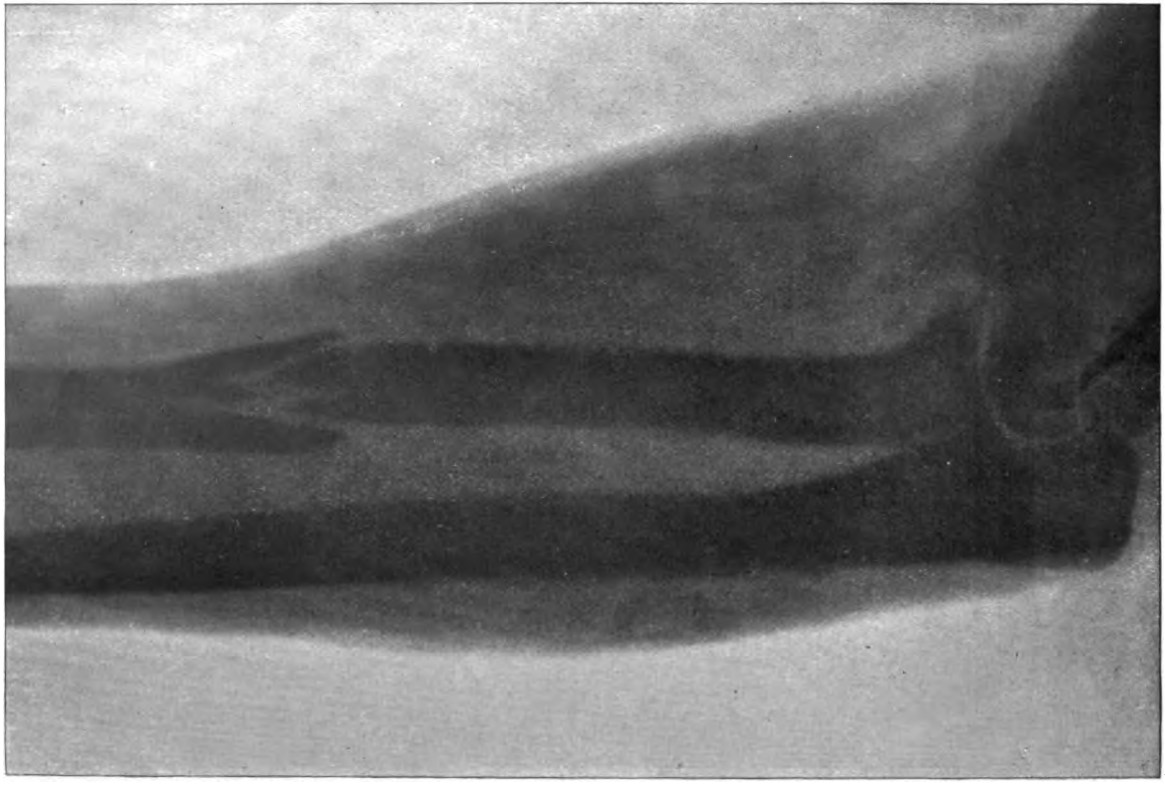

FIG. 14.—Impacted fracture of radius.

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HIP DISEASE, ITS EARLY DIAGNOSIS AND MECHANICAL TREATMENT.

GEORGE W. ROBERTS, M.D., NEW YORK.

Not infrequently do we meet cases of hip disease which have advanced to a stage of marked, even permanent, deformity, with abscess formation, pronounced systemic disturbance, prolonged suppuration, and all sorts of complications, which, notwithstanding they have been under a physician's care for weeks and months, have never been recognized positively as hip disease. It is with the hope of stating briefly and clearly the most important points in connection with the early diagnosis and best mechanical treatment of this all too common malady that your valuable time is trespassed upon.

In order to refresh our memory a few general remarks upon hip disease may not be out of place, although we feel sure that its pathology, course and symptoms are very familiar to all. The terms coxitis, coxalgia, morbus coxarius, hip disease, hip-joint disease, chronic articular ostitis of the hip, tubercular disease of the hip, each has been advocated as the most appropriate name for this condition by various authors. Since the disease may begin in different portions of the joint, it is difficult to give a name which will cover the pathology of all cases. It is, however, pretty thoroughly understood that every case of hip disease is tubercular in its nature. Therefore, to be exact, each case should be designated by adding to the word "tubercular" the exact anatomical location of the process. This, however, is confusing, and as a general term must be employed, we think it better to employ the term hip disease, understanding by that, a tubercular process beginning in some one of the elements making up the hip joint, characterized of course by the presence of the tubercule bacillus of Koch, and attended by the phenomena which always accompany the development of this germ in the human system. The process may originate in the os innominatum, in the head, neck or upper

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portion of the femur, and is said sometimes to take its origin in the synovial membrane lining the joint. The causes of hip disease, like those of all tubercular joint diseases, are of a two-fold nature, predisposing and exciting. The predisposing causes are, again, of two classes, hereditary and acquired. Hereditary predisposition to all tubercular lesions is present in every child born of parents whose fathers or mothers, brothers or sisters have had the disease. The acquired predisposition to hip disease follows an attack of any of the exanthematous fevers of childhood, being especially marked after measles, scarlet fever, and whooping-cough. In almost every case of hip disease, either the acquired or hereditary predisposition can easily be traced after a few moments' intelligent questioning. In the Laura Franklin Hospital, in New York, we have quite a large service in tubercular diseases of childhood, and the writer does not remember having met with a single case in which he did not satisfy himself of the presence of either the hereditary or acquired tendency. Little is at present known regarding the exciting causes of hip disease. The *theory* is, however, and it seems well-established, that traumatism furnishes the locus minoris resistentiæ which determines the location of the tubercular process. As our text-books cover the symptoms, pathology and course of development so thoroughly, let us turn immediately to the more practical question of diagnosis.

The late diagnosis of hip disease is so apparent, that an examination is hardly necessary; the general symptoms of tuberculosis and possibly continued suppuration, the characteristic deformity and gait, are so familiar, that they mark a case almost as plainly as though the patient carried a placard. Not so, however, with the early stages of the disease. Indeed the diagnosis is either so difficult or so poorly understood, and we believe it is usually the latter, that fully four-fifths of the cases which come to the orthopædist come after a certain amount of irremediable deformity has taken place. The early stage of the disease has passed, the tubercular affection has extended from one portion of the bone to another, has invaded the joint, the soft tissues about the joint, and very likely abscess is imminent.

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The day when complete repair can be accomplished, when the case can be cured without deformity, has been frittered away, and only too often does the physician fail to make a positive diagnosis until that diagnosis is apparent even to the layman. This sort of neglect is not only reprehensible, but ought to be classed under the name of malpractice, for with due attention to detail, and even a moderate knowledge of the nature of the disease, a diagnosis ought to be reached in every case of hip disease long before a permanent deformity has taken place.

In order to prepare oneself to diagnose hip disease it is only necessary to thoughtfully consider the four conditions which attend the development of this lesion, and which underlie all that long list of symptoms and signs with which we are taught to burden our minds. These four conditions are, in order of their diagnostic importance, (1) muscular spasm, (2) atrophy, (3) pain, (4) joint-tenderness. Considering these conditions in detail, it may be said that muscular spasm is the all important result and most diagnostic sign of hip disease. It begins with the onset of the disease, whether that onset takes place in the head of the femur, some portion of the acetabulum, or in the synovial membrane lining the joint surfaces. It is distinctly a reflex, not dependent in any way upon pain or tenderness, but is one of those obscure nervous outcries which tell the practitioner of the hidden disease long before the brain of the patient even has been notified of its existence. This spasm is a constant condition, is *never* absent in hip disease. It affects one or more groups of muscles governing the motion of the hip-joint, and while the patient is awake it never relents. During sleep and anæsthesia the spasm subsides only to reassert itself suddenly when consciousness approaches. It is tonic in character, and results, therefore, in a more or less well-defined malposition or limitation of motion of the hip-joint.

Second—Atrophy originates in very much the same manner as does the spasm. Properly speaking, however, it has two causes. First, it is caused by a peculiar reflex, which apparently interferes with the nutrition of the muscles, causing them to waste progressively. Second, it depends somewhat upon restricted use of the limb. The result of these two causes is, that those

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muscles which control directly the motions of the joint seem to be most pronouncedly affected by the reflex atrophy, while the atrophy of those situated more remotely in the limb, the calf muscles for instance, depends largely upon non-use. With the beginning of the disease begins atrophy, and one rarely or never meets a case of hip disease so early in its development that atrophy cannot be demonstrated.

This condition progresses with the disease until the difference in circumference between the well and diseased limb is from a half inch to three inches in the thigh, and from a quarter of an inch to an inch and a half in the calf.

Third.—*Pain* is by no means chronologically the first symptom of hip disease; indeed, it is sometimes entirely absent. Ofttimes it does not put in an appearance until other pathological conditions are well marked, and it is then somewhat peculiar in its distribution. It varies in intensity from those indefinite wandering pains, known as growing pains, up to the acute ache, which becomes a terror to the patient and compels him to cry out in agony. Sometimes its location is in the region of the hip itself, possibly above Poupart's ligament, sometimes in the front of the thigh, and more rarely in the leg; but its most frequent location is to the inner side of the knee-joint, over that region supplied by the cutaneous division of the obturator nerve. In the milder cases it is present only after strong exertion, while in the more severe cases it ofttimes becomes a constant symptom, depriving the patient of sleep, and compelling him to hold the limb with his hands in order to obtain relief.

Fourth.—Joint-tenderness is an early condition in many cases, but is sometimes absent, and is altogether less reliable than either spasm or atrophy. It is elicited by increasing the intra-articular pressure in any manner whatever, notably by a step or sudden jar upon the heel, by deep pressure over the joint itself, either anteriorly or posteriorly, and by pressure against the trochanter major.

These four conditions are, within the limitations given above, the constant accompaniments of hip disease. They are developed early, and are either directly or indirectly the cause of

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all signs and symptoms met with in hip disease, with the exception of swelling and so-called abscess, which are late symptoms, and are dependent upon the invasion of the soft parts by the tubercular process.

We may safely assert that any symptoms dependent upon spasm of muscle, joint-tenderness, atrophy or pain about the hip-joint (and in a case of pain including the knee-joint) should arouse suspicion and direct one's attention to the possibility of developing hip disease. This *suspicion* is strongly reinforced by the presence of an hereditary or acquired tendency and a history of an exciting cause. Attention having been directed to the hip-joint, a careful examination is imperative. In an examination of the joint for suspected hip disease, method and thoroughness are all important, and the examination should be conducted in the following manner: The history of the case having been carefully taken, the patient is stripped to the skin, for no man is justified in pronouncing a patient free from hip disease when his examination has been conducted with any clothing upon the body. In a naked condition the gait is to be carefully observed, remembering that "hip limp" is in its early stages rather a stiffness of the joint than an actual limp. Next, with the patient standing with his back toward the doctor, the gluteal folds are carefully observed, and the shortening or decrease in depth of one fold, as compared with its fellow, is to be taken as evidence of either slight flexion, swelling or atrophy of the limb. The patient is next placed upon a flat table, lying upon his back, with the well limb flexed at such an angle that the forearm of that side can be locked underneath the popliteal space, thus holding the spines of the lumbar vertebræ in contact with the table. The attempt is now made by pressure upon the anterior surface of the knee of the suspected limb to bring the popliteal space in contact with the table. If this can be done, it demonstrates the absence of spasm in the flexor muscles of the thigh. This test alone might almost be relied upon to settle the diagnosis, so universal is spasm of the flexor muscles. Straightening now the well limb, and using it as a model from which to judge the restriction of motion in its fellow, we test the capacity of the two limbs separately, begin-

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ning with flexion. This is done by grasping the limb at the ankle and knee and gradually flexing the thigh as far as possible upon the abdomen. If there is present spasm of the extensors, the pelvis begins to tilt at a much earlier limit than otherwise. Placing now the thumb and second finger of the left hand on the right and left anterior superior spinous processes, in order to steady the pelvis and act as an index to its motion, abduction and adduction of each limb is tested. The limitation of either proves spasm of the antagonistic set of muscles. Again taking the well leg as a model, the most important test of all is made by flexing the thigh to a right angle with the abdomen, abducting it to about forty-five degrees, and, with the leg for a lever, rotating it in this position. This is known as "rotation in abduction and flexion," and any limitation to this motion is extremely suggestive of beginning hip disease, and requires only the slightest confirmation to render the diagnosis positive. On the other hand, it is impossible for there to be present even the beginning of hip disease without the presence of at least a slight catch in manipulating the head of the femur while in this position. It must be borne in mind, in this connection, that children sometimes resist voluntarily, but it is always possible to divert their attention in such a manner that volition is eliminated, and under these circumstances the slightest catch is to be given its due weight. Turning from the motion of the limb, careful measurements are now to be taken of the circumference of the two limbs at the hip, the centre of the thigh, and the largest portion of the calf. Atrophy is present in at least a slight degree in all cases of hip disease. Next in order will come measurements of the length of the limbs, measuring first from the anterior superior spine to the internal malleolus, and next from the umbilicus to the same point. The former demonstrates real shortening and the latter apparent shortening. While there are many other signs and symptoms of hip disease, we contend that any conscientious physician, even though he is not a specialist, can base an absolute diagnosis upon the examination outlined above in every case of beginning hip disease, and that any man who is in doubt about the diagnosis for longer than ten days is

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either careless, obtuse, or afraid to find out what is the matter; and we wish to say, further, that this diagnosis having been arrived at in the method described, no further examination of the case should be made for at least eighteen months, but efficient mechanical treatment should be instituted at once.

Treatment.

The treatment should be considered under four headings: First, medical and hygienic; second, mechanical; third, operative; and fourth, treatment of the complications. For lack of time, however, we will ignore everything except mechanical treatment, which we consider by far more important than all other agencies which can be brought to bear upon a case. The mechanical treatment of hip disease is conveniently divided into, first, preparatory treatment, and, second, ambulatory treatment. Preparatory treatment should begin at once in all cases in which there is present at the time the diagnosis is made any marked deformity in the form of flexion, abduction or adduction, and should consist in absolute fixation of the patient's body and well limb in the horizontal position in bed and traction upon the sick limb in the line of its deformity. This fixation is best accomplished by enveloping the well limb and body in a thick layer of absorbent cotton, and applying a straight outside splint extending from the axilla to the ankle of the well limb. This splint should be made fast by means of a plaster-of-Paris roller, which should envelop the entire well limb and body of the patient. Having fixed the patient in this manner, an ordinary Buck's extension is to be applied in such a way that it exerts traction upon the sick limb in the line of its deformity. This extension is supplemented by another weight and pulley, so attached to the upper third of the thigh that it gives a pull outward over the side of the bed. If this lateral weight is one-third as heavy as the linear weight, the resultant of these two forces is traction in the line of the neck of the femur. This traction is kept up day and night, using on the linear side a weight varying from four to sixteen pounds, until the spasm of that set of muscles which holds the limb in its deformed position has somewhat relaxed, this period

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usually being from four days to a week, at which time the limb will be found to be easily placed in a more correct position; the extension is so shifted as to draw in this new line of deformity. This process is repeated every few days until the leg is practically straight with the body and parallel with its fellow. When this is accomplished, and not till then, we are ready to apply a splint. Now, there are many forms of hip splints, so many that even an enumeration of them is confusing. We may fortunately, however, divide all methods into three principal classes: First, simple fixation, represented by the plaster-of-Paris spica, Vance's leather splint, Thomas's splint, etc.; second, extension (without fixation), represented by Davis's, Sayre's, Taylor's and a host of other splints, including Hutchinson's "physiological method;" and, third, a combination of fixation and extension, represented by Phellps's splint.

A discussion of the principles underlying all these different splints and the results attended by their use would consume too much time, but we wish to say, in brief, that a careful observation of the results of these various methods, as seen in the clinics of New York, as demonstrated in our own practice, and as recorded in the literature on this subject, has thoroughly convinced the writer that the third, or the method of combining fixation with extension, thus attaining as perfect rest of the joint as possible, is incomparably superior to all other forms of treatment.

By an early diagnosis and the intelligent use of this method of treatment, it is my firm belief that nine-tenths of all cases of hip disease ought to be cured without material deformity, without the formation of abscess, without operation, and without serious impairment of general health. The other tenth, or the most serious cases, will show a large mortality, due usually to the development of tuberculosis of other portions of the body—*i.e.*, the meninges, other joints, the lungs, etc. Unquestionably a few cases will, in spite of the best-directed mechanical treatment, show serious local complications; but these cases are, with this method of treatment, exceedingly few, and one who has not tried treating the early cases of hip disease by absolute fixation and traction in two

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directions, as described, can hardly appreciate the advances which have been made in the treatment of this disease within the past fifteen years.

STRANGULATED HERNIA AND THE MURPHY BUTTON.

H. L. NORTHROP, M.D., PHILADELPHIA.

A SIMPLE, innocent, every-day rupture becomes a menace to life and health when, after so-called taxis performed by the patient, or the well-directed efforts of the medical attendant, it cannot be reduced. If to this irreducibility there be added interference with the circulation of the part hernially protruded, or impediment to the return of material from this part to a distal portion of the alimentary canal, a condition of strangulation is said to exist. What are the symptoms of strangulated hernia?

An irreducible tumor (hernia protrusion); a doughy "feel" to this tumor; local pain and sensitiveness; general abdominal pain; the so-called abdominal face; collapse; symptoms of obstruction of the bowel, viz., inability to move the bowels enough to relieve concomitant symptoms, such as distention, nausea and vomiting.

The treatment of strangulated hernia consists in the relief of the strangulation either by taxis or by operation.

Taxis, single and alone, rarely, if ever, brings about a reduction of a strangulated hernia. The very word strangulation implies irreducibility. Taxis, then, is not sufficient, and we must apply more potent means to accomplish the desired result.

There is no better aid to taxis than a general anæsthetic, but this should not be given unless all preparations have been made for immediate operation, should taxis fail. The effect of the general anæsthetic is to relax the muscles and structures in the neighborhood of the constriction, the ring, and thus favor the successful performance of taxis.

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But we appreciate the fact that a hernia should be reduced just as soon as possible, and if symptoms of strangulation are present or impending, this is all the more necessary. The general anæsthetic is supplemented by the application of cold, as furnished by the ice-bag or by the local use of ether. To the former must be given the credit of bringing about the reduction of many herniæ; the ice-bag, therefore, is a valuable aid in overcoming irreducibility and strangulation. Cold lessens the congestion and inflammation and tends to deplete the hernia. Ice-cold water, poured upon the surface of the tumor from a height of two or three feet, or a spray of ether, are advised. Nothing is truer than that much valuable time is lost in bringing about a cold condition of the hernial contents. Many do not know how to effectively use the cold-producing agent. It is therefore the physician's duty to see that the ice-bag, for instance, is correctly and continuously applied.

I wish now to suggest the use of chloride of ethyl, a local refrigerant and a powerful and rapid freezing agent, in the reduction of strangulated herniæ by taxis. Instead of consuming hours for an ice-bag to lessen the congestion, why not accomplish the same result in a few minutes? The saving of time here means the prevention of an operation, or if not the prevention of a herniotomy, then the prevention of a resection of the bowel. Spray the tumor continuously with chloride of ethyl until the surface is frozen and the cold has had opportunity to penetrate to the parts within. This is a quicker, surer way of applying cold than by any other available means. If not on hand, use ice until the chloride of ethyl can be obtained.

If the hernia cannot be reduced and the strangulation relieved, the sac must be laid open and the constricting ring and bands incised. Hot water should be used freely and persistently to revive the choked, strangled loop of intestine or piece of omentum; and if the blue or black color of the part that has been constricted persists, instead of changing to one less dark—if the dull, non-glistening appearance, the soft, flabby, doughy consistency, the greenish spots (indicative of gangrene)—if these conditions cannot be removed, the life of the bowel being

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seriously impaired or lost altogether, resection is the only alternative.

As it is not my object to enter into a comprehensive study of any part of my subject, purposely omitting details, I simply wish to outline the method of procedure in a bowel resection, making the anastomosis by means of a Murphy button.

Empty the bowel as far as possible of fecal fluid, gas, etc., and while an assistant firmly grasps the intestine well beyond the gangrenous portion, cut out the latter with scissors, continuing the incisions into the mesentery, converging them until they meet at the apex of the V-shaped piece thus excised. By catgut suture unite the two legs of the "V," beginning at the apex. Now insert a purse-string suture of catgut around the margin of the cut ends of the intestine, place one-half of a Murphy button in each end, hold it *in situ* by tightening and tying the purse-string suture over its inner margin. Lock the two halves of the button, and the operation upon the intestine is completed, unless the operator chooses to encircle the gut with a continuous suture at the line of approximation. Murphy claims that this is not necessary.

Permit me to report three cases of stragulated hernia with resection of the bowel *a la* Murphy.

Mrs. R., 45 years, a patient of Dr. W. K. Ingersoll's. Right femoral hernia for years; never wore a truss. For past seventy-two hours hernia has been out and she cannot put it back. Severe pains, considerable distention, temperature 103°, pulse 124, nausea and vomiting. Advised taxis under ether, and, if this fails, immediate operation. Patient was etherized, taxis ineffectual, operation begun. Upon opening the sac a gangrenous coil of ileum presented itself. After division of the constriction, hot application failed to resuscitate the blackened loop; resected four inches of the bowel, uniting the ends with a Murphy button. Did not insert the continuous, circumferential suture at the line of approximation. Patient recovered nicely, and a dose of licorice powder brought away the button forty-five days after the operation. She lived for one year after without any symptoms referable to her abdomen, dying of organic heart trouble.

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Mr. T., 28 years, patient in the Hahnemann Hospital. Right inguinal hernia, with complete picture of strangulation. Operated under chloroform and oxygen seventy-two hours after hernia appeared. Loop of intestine was gangrenous, could not be revived, six inches were resected, and the ends approximated by a Murphy button. In this case I used the circumferential suture. Patient recovered without complication and passed his button on the seventeenth day after his operation. I saw him six or eight months afterward, when, although in poor general health, he had no abdominal symptoms indicating trouble at the seat of operation.

Mrs. H., 64 years, a patient of Dr. William C. Powell's. Umbilical hernia for years. Rupture out for the past fourteen hours (or probably more), and irreducible. Severe vomiting, intense pain and other symptoms of strangulation. Taxis fails. Ice, ether and chloride of ethyl were faithfully tried, but the hernia could not be reduced. Advised operation. Because patient's condition was so precarious a general anæsthetic could not be administered, but twelve inches of gangrenous bowel were resected, anostomosis was made with the Murphy button and a large piece of omentum was amputated under a subcutaneous injection of cocaine, a four per cent. solution, the patient suffering but a trifle. Old, firm adhesions between the sac and the piece of omentum partly explained the failure at reduction by taxis. The constriction was so great, however, that without these adhesions reduction would probably have been impossible. In this case I did not use the circumferential suture.

The patient lived for seventy-two hours and died from chronic Bright's disease, having passed but one and one-half ounces of urine from the time of her operation until her death. She had no symptoms whatever of peritonitis or extension of the gangrene after her operation. The bowels moved nicely, the abdomen was flat and soft, there was no vomiting, and she retained and relished liquid nourishment administered per orem et per rectum. A post-mortem examination was refused.

In this brief paper I have endeavored to point out the probable value of chloride of ethyl as an adjuvant to taxis in re-

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ducing irreducible or strangulated hernia, and to advocate the use of the Murphy button in the anastomosis of resected parts of the alimentary canal.

FRACTURES INVOLVING THE ELBOW-JOINT.

WALTER STRONG, M.D., PHILADELPHIA.

It is with a certain degree of hesitancy that I presume to occupy your time and attention by the discussion of a subject which may seem so commonplace in these days, when the surgeon's pen is expected to bring forth something decidedly startling, or the report of some new and heretofore unheard-of operation. Unfortunately, I have nothing of such an interesting character to offer you, but hope that you will be kindly indulgent with me for a few moments while I call your attention to certain mooted points in the management of fractures involving the elbow-joint.

Of all fractures met with in surgical practice there is probably no one so liable to complications, both surgical and legal, as a fracture occurring in close proximity to the elbow-joint. The professional risks which are inseparable from the management of these injuries inspired the pen of one of our most eminent surgeons (Gross) when he wrote that he knew of no fracture which he approached with more doubt and misgiving than that of the lower end of the humerus.

A wide diversity of opinion has long existed among surgeons of prominence regarding the most promising mode of treating these fractures, not only as to the position of the arm, whether flexed or extended, but also as to the advisability of employing early passive motion to the joint.

These and other disputed points regarding the treatment, together with the frequency of the accident and the necessity of maintaining the functional integrity of the joint, make this subject an interesting one to not only the surgeon, but also to the general practitioner, who is not unfrequently called upon to treat these cases.

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If an enumeration be made of all the fractures occurring in the region of the elbow, we would find that in more than ninety per cent. of the cases the osseous lesion would involve the condyles of the humerus, and that of these fractures of the humerus, fractures of the internal and external condyles taken together would constitute nearly three-fourths of all (Stimson), while the remaining fourth would comprise the supra-condylar, the inter-condyloid, and T-fractures.

We would also discover that fractures of the internal and external condyles were of about equal frequency, and that the same ratio exists between supra-condylar and inter-condyloid fractures; we would also find that the vast majority of these fractures occur in children between the ages of five years and puberty (Lane), and that they are comparatively rare after the age of forty (Brun).

It is not my intention in this paper to enter into a detailed description of all the special fractures occurring in this region, but to occupy the limited time at our disposal with a discussion of the causes leading to ankylosis in these cases, and the means by which such unfavorable results may be most surely avoided.

When it is remembered that the elbow-joint is the centre of sextuple action, over which pass, are inserted into, or arise from, six separate sets of muscles, which are concerned in the flexion and extension of the forearm, and of the fingers and hand, as well as the pronation and supination of the hand and wrist, we may perceive and better appreciate the disastrous consequences which may attend a lesion disturbing its integrity.

The frequency with which limitation of motion follows these fractures cannot be established by statistics, having been unable to discover any reliable statistics bearing upon this point. Nearly all of these cases are treated in dispensaries, and the ultimate result seldom forms part of the record. In those cases where the result is mentioned, it is usually described as being "perfect," or "good," and only rarely as "poor."

That fractures occurring in the region of the elbow-joint are especially liable to be followed by more or less limitation of motion, is a fact beyond the possibility of a doubt. This fact is very forcibly impressed upon us in looking over the litera-

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ture upon this subject, where we find that, while there is a great diversity of opinion regarding the treatment, all authorities agree that the prognosis should be guarded.

Astley Cooper tells us that while, in the majority of the cases, fair use of the limb will result, a guarded prognosis should be given, as ankylosis frequently occurs, regardless of the skill and attention bestowed.

Gross tells us that even in the simpler forms of these fractures, when the treatment is skilfully conducted, there is great danger of unfavorable results.

Bryant says that fractures of the condyles of the humerus into the joint are always followed by ankylosis.

Hamilton, in his well-known work on this subject, advises a guarded prognosis in all cases.

Packard says that the course and results in these fractures are liable to be very bad, and advises a guarded prognosis.

Boyer, Dupuytren, Desault, Fano, Larrey, Chassaignac, and others, in writing upon this subject, express themselves in a similar tenor.

Permanent limitation of motion at the elbow following these fractures is commonly due to one of three conditions: 1. A change in the shape of the articular surfaces of the humerus. 2. An overgrowth of bone upon the surfaces of the humerus. 3. An ossification of the capsule and ligaments, each of which we will consider more fully, and endeavor to determine the causes leading to the development of these pathological conditions.

The normal range of motion at the elbow between flexion and extension lies between 35° and 172° (Masse). Over this large joint surface the bones composing the elbow are in close and accurate contact with each other. It naturally follows that a comparatively slight change in the shape of these bones will cause a marked disturbance in the function of the joint. Such a condition is one that can only be partially relieved by a gradual yielding of the ligaments or by the absorption of the bone under the influence of long-continued pressure.

An overgrowth of bone upon the surfaces of the humerus is frequently a cause of limitation of motion in these fractures.

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This overgrowth is in part exuberant callus and in part new bone, and may occur directly at the seat of fracture or under the periosteum near the fracture. This is a condition quite frequently found following these fractures, due, to a large extent, to the fact that these fractures are usually found in quite young persons, in which there is a greater activity of the elements that participate in the reparative process and frequently lead to a hyperplasia of the bone. This is also more likely to take place where there has been great displacement of the fragments or where the fracture has not been well reduced.

A thickening of the ligaments and surrounding tissues of the joint by the products of inflammation is a very common condition observed after these fractures, and may cause temporary or permanent limitation of motion at the elbow. These fractures are always attended with more or less injury to the soft parts, and in many cases this injury to the soft parts is of such a serious nature as to lead to marked pathological changes in the adjacent tissues. As a temporary condition the anatomical changes are limited to an exudate which infiltrates the surrounding tissues, and which promptly and completely disappears after the repair of the main injury and the cessation of irritation. As a permanent condition we find that the changes are of a far more serious and extensive character. Here we find that a tearing of the soft parts has resulted in the development of considerable cicatricial tissue, which binds together the various parts of the joint; also that there has been more or less destruction of the synovial membrane of the joint, together with a thickening of the capsule. If the inflammation has been severe and long-continued we may find that this new and thickened tissue has become more or less ossified, and that we have a joint completely and permanently ankylosed.

We will now briefly consider those points in the treatment of these fractures which have a material bearing upon the development of the three conditions just mentioned.

The importance of an early and accurate diagnosis in these cases is so apparent that very little argument is necessary upon this point. Without a knowledge of the exact location and character of the osseous lesion we cannot adopt those measures

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best suited to that particular case. We now have at our disposal a most accurate method of diagnosing these cases. I refer to the use of the Roentgen or X-rays, by means of which we are enabled to see at exactly what point the fracture exists, as well as its relationship to the surrounding bones. At the present time I simply call your attention to this means of diagnosis, and will speak more fully of its use in a future communication.

Considerable diversity of opinion has always existed among surgeons as to the most favorable position for the arm in treating these fractures. At present we find surgeons about equally but hopelessly divided between the flexed and extended positions. So much has been written regarding the respective merits of these positions that very little remains to be said.

Personally, I am not wedded to any particular position in the treatment of these fractures, although I am free to admit that I favor the flexed position. My sole reason for favoring the flexed position is the fact that I have succeeded in treating thirty-three cases of fracture in the region of the elbow with results satisfactory to myself as well as to my patients.

But I am not narrow-minded enough to say that all cases should be treated in this position, nor that as good results cannot be obtained with the extended position. Were I to meet with a case where complete reduction could not be maintained with the arm in the flexed position, I would not hesitate to treat such a case in the extended position.

Some of the more enthusiastic advocates of the extended position claim that it is impossible to treat these cases in the flexed position without a loss of the outward angularity of the forearm upon the arm, or that we will lose the carrying power of the arm. This I do not think is warranted by the facts of the case, for there is nothing in the flexed position to interfere with this relation of the radius and ulna to the humerus, and even if there be a slight degree of cubitum varum present I do not think it a serious objection so long as it be not excessive.

Unfortunately we have no statistics showing the respective results of the flexed and extended positions, apparently as many cases of ankylosis occurring under the extended position as with the flexed. We do know that ankylosis frequently occurs

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with both positions, also that an upper extremity, with a stiff elbow-joint, having the arm in the extended position, would be the source of much disability and the cause of much discomfort, while the same condition, with the arm in the flexed position, would be very useful in many ways to the patient.

Smith, of Boston, has recently reported a series of thirty cases of these fractures successfully treated with the arm acutely flexed, and claims that the range of motion was greater and the deformity less than in any other position. Warren, McGraw, and a few other surgeons also favor this position.

It might be of interest to know how some of the more prominent surgeons of to-day treat these fractures.

Among those favoring the extended position may be mentioned Allis, Roberts, Willard (of Philadelphia), Dennis, Gerster (New York), Fowler (Brooklyn), Park (Buffalo), Senn (Chicago), Lane (San Francisco).

Among those using the flexed position we find Bryant, Harrison, Horsley (of London), Czerny (Heidelberg), Abbe, Sayre, Stimson (New York), Keen, White, Morton, Ashurst, Packard, Deaver (Philadelphia).

Another very important point in the treatment of these fractures which is in dispute, is that of passive motion. Upon this point surgeons hold widely divergent views, some claiming that persistent and early passive motion is the only safeguard against ankylosis, while others believe it favors ankylosis, and in many cases it is the sole cause.

To my mind this is the most important point in the management of these fractures, and that more harm arises from the early use of passive motion than from all other causes put together. Stimson put it very ably when he said that "the ankylophobia of the surgeon is more dangerous than the traumatism."

The pernicious advice of Hamilton urging early passive motion in elbow fractures is probably responsible for many stiff joints following these fractures. Concerning which he says, "At a very early date, so early, indeed, as the seventh or eighth day, the splint should be removed, and while the fragments are steadied the joint should be subjected to gentle pas-

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sive motion, and should be repeated as often as every second or third day, in order to prevent, as far as possible, ankylosis." So many surgeons have blindly followed this advice it is not surprising that we meet with so many cases of ankylosis, the result of these fractures.

The advocates of early passive motion base their belief on the fact that if a joint is kept movable it will not become stiff, and partly from the clinical observation that many joints that have been treated by passive motion have regained their function. They claim that no delay is permissible; a week, ten days, or a fortnight at the latest, after the injury we must begin our passive motions. Since the object of this passive motion is to stretch or break the bands which are forming within the joint, the movements must necessarily be carried beyond the points where resistance begins.

The patient endeavors to stand these painful manipulations as best he can, but in spite of his fortitude his muscles involuntarily contract and make the range of easy motion less and less. At the next attempt we find the range of motion somewhat less, the manipulations more painful, and also that the joint is more or less swollen. These conditions become more pronounced after each attempt at passive motion, until finally the patient refuses to allow the movements to continue or the surgeon recognizes the onset of acute inflammatory symptoms. The surgeon then waits a few days, perhaps, then, under ether, "breaks it up," but again it stiffens and he is compelled to give up the struggle. After the swelling and soreness disappear we have one of two results: the joint either remains permanently stiff or gradually regains its function under the natural use of the limb.

Phelps, at Loomis laboratory, New York, recently conducted a series of experiments upon the lower animals, with a view of determining the cause of ankylosis. Those experiments proved conclusively that ankylosis was not due to immobilization. The conclusions which he arrived at were: 1. That a normal joint will not become ankylosed by simply immobilizing it for over five months. 2. That motion is not necessary to preserve the normal histological character of a joint. 3. That when a

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healthy joint becomes ankylosed it is not due to prolonged rest, but to pathological causes.

If these experiments prove that ankylosis is not due to prolonged fixation, and that motion is not essential for the preservation of the normal function of a joint, then ankylosis must depend upon pathological changes in the joint. In which case, how can passive motion be of use in these fractures?

In all fractures about the elbow-joint we have more or less injury to the soft parts. This injury consists in a laceration and contusion of the tissues surrounding the joint, also a tearing of the ligaments, as well as peeling off of the periosteum at the seat of fracture. Following the injury, we have an inflammation set up in all the tissues surrounding the joint, as well as an acute synovitis in the joint itself.

How shall we treat such a condition of affairs as I have just described? Were it not for the osseous lesion which exists, all would agree in advising complete and absolute rest to the injured parts. We would adopt those measures which we would employ in an inflamed condition in any other portion of the body. But on account of the existing fracture many insist that we shall in a large measure dispense with our best antiphlogistic measures which we employ in all other inflamed conditions, and adopt an entirely different plan of treatment. According to their mistaken idea we must carefully reduce the fragments, apply such a dressing as will retain the fragments in place, and put the limb at rest. But this period of rest must not continue longer than a week, at the end of which time we find that the symptoms of inflammation have subsided and everything is doing well. We must now commence our passive motion, which means that we must break up all the union which has already taken place in the tissues. We again start up our inflammatory action, and possibly by our meddlesome manipulations excite an overgrowth of callus, which is one of the things which we desire to guard against. With such treatment it is nothing short of a miracle that any of these cases recover the function of the joint.

Now let us take a look at the opposite side. We carefully reduce our fracture and apply suitable dressing, sour inflamma-

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tory symptoms subside, and we simply change our dressings so as to keep them snug and our patient comfortable. Having been sure that our fragments were properly reduced at the start, we are not at all inquisitive, but perfectly willing that nature shall take its course. At the end of four weeks we finally remove our dressings, and perhaps discover some slight stiffness, which, if not due to a change in the shape of the articular surfaces of the bone, will gradually disappear with the natural use of the arm.

Compound fractures involving the elbow-joint are always very serious accidents, and usually followed by complete ankylosis. Such being the case, all such fractures should be treated with the arm in the flexed position, so that if ankylosis does occur we have the arm in the most useful position for the patient. Ankylosis, however, does not always follow these fractures. About eighteen months ago I had under my care at the Women's Homœopathic Hospital one of the most serious compound fractures of the elbow which I ever met, in which a most favorable result was obtained. Patient was a boy who was hit by an express train. Among other very serious injuries was a compound, comminuted fracture of the condyles of the humerus, in which there was extensive laceration of the tissues and laceration of the vessels. Under ether I enlarged the openings and found bone ground into quite small fragments, and although I had permission to amputate, decided to endeavor to save the limb; after removing the loose fragments, which consisted of the entire condyles, and after controlling the hæmorrhage, I applied the usual dressings under aseptic precautions, and placed the arm in the flexed position for seven weeks, at the end of which time I removed the dressings, and, much to my surprise, found quite a little motion present. This range of motion has gradually increased under the natural use of the arm, until at present he has a very useful arm, with a range of motion amounting to over ninety degrees.

Another very interesting case which recently came under my care was one in which an injury to the ulnar nerve was the cause of limitation of motion at the elbow. The case was that of a man about thirty, who six months before had had a

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severe crush at the elbow resulting in a fracture, as well as I could determine, through the condyles. Following the fracture, which apparently had united without any complications, the patient experienced considerable pain in the region of the elbow upon the slightest attempt at motion; the hand was almost useless. I advised that he submit to an exploratory incision, to which he consented; at the operation I found the ulnar nerve closely bound down to a mass of new bone. I carefully liberated the nerve from its new attachment and sewed up the wound; there was almost immediate cessation of pain, and since there has been a slow but gradual return of the function of the limb.

A CASE OF BRAIN ABSCESS.

D. P. MADDUX, M.D., CHESTER.

Mr. I.; married; æt. 38; by trade, an engraver; of excellent family history and good previous health; consulted me first in regard to the illness to be described, on May 18, 1895, complaining of ear pains and the other ordinary symptoms of abscess of the middle ear; on the next day the abscess broke and the characteristic purulent discharge in considerable amount followed.

Although considerable relief was obtained from the pains in the ear, there ensued a very persistent and painful supra-orbital neuralgia of the affected side. For two weeks the ear continued to discharge copiously, in fact more copiously than any otitic abscess that had ever come under my observation; but barring the supra-orbital pains there were no symptoms of an unusual character.

On the evening of the 4th of June there was a return in great violence of the deep-seated, intolerable pains in the ear. On the 6th of June there was a discharge of blood and bloody pus from the ear; this I interpreted at the time to signify an invasion of the inner ear; and as there was no swelling or

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sensitiveness over the mastoid, and as the bloody discharge seemed to give a relief to the deep-seated pain, and as there was no chill or marked elevation of the temperature (it was only 100° F.), I felt myself warranted in believing that the discharge was finding adequate drainage through the natural channels.

The local treatment at this time, as throughout the case, was copious washings with hydrogen peroxide. The supra-orbital pains, however, renewed their maddening torment. They were not intermittent twitchings, but a steady, persistent suffering confined to the region indicated.

Early on the morning of June 12th I received urgent summons to see him, when, to my surprise, and almost consternation, I found the following conditions present: He lay in a comatose condition from which it was very difficult to arouse him, the entire left side seemed to be completely paralyzed (it was the right ear that was affected), no motion, no sensation, left pupil stationary and irresponsive to light, tongue protruded with difficulty and deflected to the right side.

I immediately telephoned to Prof. William Van Lennep, and he arrived shortly before noon. He advised first a trephining of the mastoid; accordingly he was anæsthized by Dr. Grigsby, and assisted by Drs. I. Crowther, George Webster and myself, Dr. Van Lennep trephined the mastoid cells, and by chisel and gouge worked down to and cleaned out the middle ear. Some congestion was found, but no free pus or broken-down bony tissue discovered except in the cavity of the middle ear.

The man was put back to bed and his condition closely watched. No signs of reaction appeared; unconscious defæcation and urination, a weakening pulse, labored breathing, non-reactive pupils, a failure to exercise on single voluntary muscle, warned us that we had not reached the seat of the difficulty. Towards evening positive indications of pulmonary œdema on both sides appeared; he became bathed in a cold sweat, altogether quite a moribund picture.

About 9.30 P.M. Dr. Van Lennep, accompanied by Dr. Bartlett, again called; a hurried consultation was held; his family were told that there was a remote possibility that his life might

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be saved by an operation, but frankly told that there was a greater probability that he would die on the table.

When he was finally placed upon the table he was at the point of death.

At my earnest solicitation Dr. Van Lennep concluded to do what he could without anæsthesia; the incision of the morning operation was extended posteriorly, and to knife and trephine the patient was oblivious. The point of the trephine was inserted one and a quarter inches above and one and a quarter inches posterior to the external auditory meatus; after the button or bone was removed, the biters cut their way downwards and forwards, the dura puffed up, congested and showing some pus; after removing about an inch and a half of bone the dura was cut, when out welled pus and broken-down brain material; peroxide was poured into the apparent outlet, and out gushed a mass of soapy foam, which must have represented a very considerable amount of débris. A more careful search revealed the outlet of the abscess at the point of the temopro-sphenoidal lobe, and our nearest estimate was that the cavity was at least the size of an ordinary goose-egg.

A rubber drainage tube, two and five-eighths inches long, was introduced into the cavity; and such was our haste to finish that we did not wait to tie the vessels in the scalp, but left on the hæmostatic clips, dressing with the ordinary antiseptic toilet.

During the time of operation the patient never moved any part of his body, but those who were watching him said that his pulse improved in tone during the operation.

After being placed in bed, hot packs were placed about him; the first medicine he received was a hypodermic injection of arnica, 3x; later, the pulse becoming more feeble and wavering, I gave 15 minims arom. spir. ammo., which temporarily produced a decidedly good effect. I spent the entire night at his bedside, the other physicians leaving about midnight. The first sign of reaction was a slight groan; next was an apparent, although unsuccessful, effort to move right leg, but, in the interval, pulmonary œdema had increased to such a degree that it made me highly solicitious. I took my stethoscope, and over the anterior

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surface of both lungs there was not a spot but where the ominous râle could be heard. About 2 A.M. I injected under the pectoral muscle one one-hundredth of a grain of antimonium crudum, dissolved in water, immediately repeating the injection on the other side; the effect was so prompt and so positive that I was more than delighted. Within ten minutes there was a very decided improvement, and within thirty minutes comparatively easy breathing; and from that time there was noticed a more decided effort to move the right side. About 3 A.M. he moved his right arm, followed soon after by a bending of the right knee; about 4, the watchers were gladdened by seeing him twitch his left shoulder. Shortly before 5 I noticed that he had appeared to swallow the mucus which collected in his throat, and, after several efforts, I succeeded in getting him to swallow some stimulants; about half an hour later, to our joy, he asked for some more whiskey.

His temperature (axillary) had ranged from 97° soon after the operation to 101°, his pulse keeping about 130. By 7 he was able to swallow easily and speak clearly, but speech was prohibited him. About 4 P.M. on the day following the operation the dressings were removed, the dura partially reunited by catgut, the abscess cavity washed out with hydrogen peroxide, and the parts about packed with iodoform gauze.

During the first forty-eight hours of the reactionary period, after consciousness was restored, the patient developed a most decided tendency to profanity, and all of us were saluted by some profane phrase. This was entirely contrary to his usual habits, as he had never been addicted to the use of profane language, and, later, he expressed a most contrite sorrow over the way he had spoken to us, at the same time saying it was without his consciousness or control.

The daily dressing of the wound, as above described, was kept up for three weeks, in which I was most capably assisted by either Dr. Crowther or Dr. Webster, and often both of them.

On the eighth day after the operation, the patient was again placed under ether, and I stitched with silk-worm gut the edges of the scalp to relieve the task of granulation as much as pos-

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sible. Eight stitches were introduced, and I obtained complete and entire union of the parts thus reunited, the stitches being removed on the eighth day.

On the twenty-ninth day after the operation I removed the drainage tube, inserting in the depression, rather than cavity, some iodoform gauze. During this entire period of twenty-nine days the drainage tube was never removed, even while dressing the wound; but the abscess cavity was washed out by inserting the nozzle of the syringe into the drainage tube.

The subsequent healing of the wound was rapid and uneventful, the cicatrix being surprisingly slight.

In the care of the wound, no step in the technique of antisepsis was neglected, and, until the wound became entirely a superficial and granulating one, the same care was taken with each dressing as with the primary operation, *i.e.*, sterilized by bichloride saturated towels surrounding wound, instruments boiled before each dressing, and myself and clean assistant careful to touch nothing not surgically clean during the time of dressing the wound.

The progress of the patient healthward was gratifyingly rapid, and his subsequent health has been better than during the same period preceding the operation. He now weighs twenty-five pounds more than he has ever done; is working steadily as an engraver, with full and complete use of all his faculties.

I have deferred reporting the case to this late day, knowing the tendency of many cases of cerebral abscess to return within a few months after operation; but as over fifteen months have now elapsed since the operation, I believe I am warranted in calling it a cured case; and, considering the size and location of the abscess, together with the patient's condition when operated upon, I believe it worthy a place in surgical annals.

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STIMULATION IN SHOCK AND COLLAPSE.

J. W. HASSLER, M.D.

PREVIOUS to 1826, Traves says, shock and collapse had rarely been employed as a surgical expression; to-day it is the most important part of surgery. Divers views are being held concerning the condition of the system in shock and collapse. Again, many surgeons do not distinguish a difference between these two conditions, but such a difference does exist.

That one or the other will exist in some degree in all cases of traumatism, whether from external forces or the surgeon's knife, is without dispute.

What I consider paramount in the study of these two forces lies in proper therapeutics. A great deal has been written concerning their pathology, but much less concerning their treatment.

Let us first consider the pathology of shock and collapse.

As I said before, various views are being held in regard to the cause and symptoms of shock and collapse. The most likely theory is that of Fisher, "who attributes the weakness of the heart's action and other phenomena of shock to a reflex vaso-motor paralysis, whereby the abdominal vessels are hyperæmic, and the heart, brain and other organs are correspondingly ischæmic."

Let us see what such a condition will produce. Take a patient suffering from some traumatism, with little or no loss of blood. Looking at his face we see eyes sunken and staring, with no expression of the face; the muscles having no motion; a cold, clammy sweat; lips and nails blue; skin anæmia; the pulse weak and thread-like; temperature sub-normal, and no loss of consciousness. Why are the above symptoms manifested? Because the vaso-motor system has been paralyzed, and the greater part of the blood has gone to the abdominal veins and arteries, and has there stagnated. This explains the mental, circulatory and muscular symptoms, for without proper

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blood-supply these organs are impaired in function. The blood-vessels being in a state of dilatation, the heart's action, being slow, fails to force the blood through the empty vessels; therefore, the tissues being deprived of sufficient oxygen, there is a lowering in bodily temperature. Now as to the cause of the vaso-motor paralysis.

Groeningen says: "After repeated mechanical irritation to the sensitive nerves there is a chemical change in them, and then they fail to respond to further irritation." This brings about fatigue and exhaustion. Reflex paralysis is an example of fatigue to nerve-centres. So we see that fatigue or exhaustion is the key as to the cause of shock, it being caused by irritation to sensitive nerve-centres.

As to collapse, the differential diagnosis between this and shock lies in the cause. In collapse there is a loss of some vital fluid, causing the following symptoms so ably described by John Bell: "The face is deadly pale; lips black; livid circles around eyes; extremities cold; patient suffering from frequent attacks of syncope; low, quivering pulse; nausea; voice disappears; anxious and incessant tossing of the arms; gasps for breath; long and convulsive sighs. The anæmia in collapse comes on gradually. The patient's condition is likely to be mistaken for one of shock if symptoms are very severe."

As to the treatment of shock. The most prominent symptom in shock is the exhaustion; therefore rest is imperative. Avoid all unnecessary handling and movement of patient; the least done to excite the patient the quicker the recovery.

The anæmia and exhaustion of the vital organs can be slightly relieved by the elevation of the foot of the bed, as the heart is too weak to replenish them. Heat is especially called for to relieve the lowered temperature. Hot black coffee in small doses and given frequently strengthens the heart and relieves nausea.

In connection with the above treatment, stimulants should be employed, but only in proportion to the degree of the shock, and should be administered in such a way as to cause as little excitement to the patient as possible.

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Alcohol has been considered the most important of all stimulants, and has been used without reserve to overcome the conditions of shock. Its use in this manner I consider erroneous and dangerous, placing its usefulness simply among the adjuvants; to be given only after the vaso-motor system has been restored to its normal condition, to give impulse to the heart.

Describing its physiological action, you will see that its sphere is limited.

According to Nothnagel, in poisonous doses it causes a severe irritation of the vagus, partly a direct affection of the heart's plexus and pneumogastric centre in the brain. This will produce a lessening of the heart's power and blood-pressure. So we see its action is simply upon that centre which governs only the heart and lungs themselves, and not upon the vaso-motor centres. If given in small doses and frequently repeated, it lowers the bodily temperature. As a stimulant it will produce a slight increase in frequency of the heart's action, and a marked increase in force, accompanying which is a dilatation of the capillaries, and what we want is a contraction, to increase vascular tension, so that the anæmic organs can be supplied with blood.

Following operations in which ether as an anæsthetic has been administered, it is incompatible.

Ether is a product of sulphuric acid and alcohol. The blood then receives a fair percentage of alcohol during the operation; if shock follows said operation, alcohol is uncalled for.

Dr. Wood, in *Dennis's Surgery*, says: "If all cases of death which have been ascribed to ether or shock could be investigated, the decision would be death from over-stimulation with alcohol."

As anæsthetist for one year and a half in the Hahnemann Hospital of this city, my observations lead me to believe that the previous statement is a fact. My records show me that in 500 cases out of 2226 there were 47 cases of shock where alcohol was administered almost exclusively; of those, 9 died and 16 failed to respond for a number of hours. In 1726 cases there were 103 cases of shock where alcohol was excluded; 2 died, 3

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failed to respond to treatment for four hours, and the rest revived very quickly.

Now, what remedies will aid us in restoring the vaso-motor system? The most efficient stimulants, as proven, are atropia and strychnia. Let us see as to their physiological action. Atropia has three chief actions. 1. It is a sedative to the peripheral nerves. 2. It acts upon the respiratory centres. 3. It stimulates the heart and vaso-motor centres.

By its action on the vaso-motor centres there is a great rise in arterial pressure, due to the contraction of the arterioles and arteries, which relieves the anæmia of the vital organs, the tissues receiving their proper amount of blood, causing a rise in temperature.

Atropia should be given hypodermically in the $\frac{1}{100}$ of a grain, and should not be repeated inside of one-half hour, for as a poisonous dose it causes paralysis of the vaso-motor centres.

Strychnia, like atropia, acts upon the motor and vaso-motor centres. But its action is a little more tardy, yet I have seen results from it in two minutes. It can be given with more impunity. I have given it as low as the $\frac{1}{10}$ of a grain. I prefer the $\frac{1}{30}$ of a grain to be repeated.

With the paralysis of the vaso-motor system relieved and the heart still remaining sluggish, an adjuvant stimulant to aid it is advisable. Of these we have a number. Those I consider most important I will name in order: Nitro-glycerine, aromatic spirits of ammonia, agaricus, alcohol, strophanthus, digitalis, and a number of others less important. But let me say, in concluding the treatment of shock, that you should never lose sight of the fact that you have a condition of exhaustion to treat, and that rest is needed for repair, and the least treatment and handling of the patient, often without stimulation, will bring about the desired effect.

In the treatment of collapse but one special point presents itself. There is a loss of some vital fluid, causing anæmia. If the loss of blood is slight the treatment for shock can be pursued, but if attended with a great loss of blood, infusion of a warm salt solution is required. The proportions are as follows:

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R.	Sodii chloridi, ...	ʒjss.
	" bicarb., ...	gr. xv.
	Aq. dest., ...	Oij.—M.

Following the use of the salt solution, either one of the adjuvants can be used if called for.

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REPORT OF THE BUREAU OF SANITARY SCIENCE.

Some Sanitary Needs of Pennsylvania, by Pemberton Dudley, M.D.
Sanitary Notes and Questions, by Bushrod W. James, M.D.
Hygiene, by Irwin B. Gilbert, M.D.
The Necessity of Disinfecting Sputa, by Alfred W. Baily, M.D.
A New Method of Preserving and Sterilizing Liquids, by L. Price Randall.

SOME SANITARY NEEDS OF PENNSYLVANIA.

PEMBERTON DUDLEY, M.D., PHILADELPHIA.

[The Committee on Publication is, unfortunately, compelled to announce that the manuscript of Dr. Dudley's paper is missing. It is not often the case that representatives of the press so far forget their obligations in handling Society matter as to carry away with them manuscript that cannot be replaced. The above paper was so enthusiastically received by the meeting that its loss in the manner indicated is all the more unfortunate. The engrossing duties of the author utterly precluded a reproduction of his ideas for the TRANSACTIONS, and the discussion following their reading is all that can be published at this time.]

DISCUSSION.

BUSHROD W. JAMES, M.D.: I am glad that Dr. Dudley read his paper before mine, so that I can probably in it help him along in his sanitary efforts. There is no doubt but that the State authorities are responsible for the contamination of our drinking-water supply. Pressure has been brought to bear upon the Legislature time and again, but thus far apparently without success. The interests of the people engaged in mining and tannery enterprises up in the mountainous sections of the State are diametrically opposed to those individuals who have

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to rely upon the purity of the drinking-water supply from the Schuylkill, which gets its main volume from the small streams coming from the upland districts where the refuse material is thrown into the creeks. We tried to get the Legislature to enact some law two years ago forbidding this contamination of our water supply, and we worked hard for the protective acts required; but all that we did accomplish was, that the law-making power did not pass a worse law or abolish what we already have. The members of the Legislature who come from the interior of the State and are interested in saw-mills, mines and tanneries, you will find outnumber the people who go from Philadelphia to Harrisburg in the interest of the purity of our drinking-water supply. The only way to accomplish this end is by a long process of education of the people all over the State; to let them understand that this condition of affairs is injurious to the health of the people, and that it kills their neighbors off by scores and hundreds.

We are sending out from the food-fish hatcheries of this State 105,000,000 small fish annually, to be distributed among the smaller streams throughout the State. A short time after this distribution we frequently find along the banks of these streams great quantities of fish which have met their death through the contamination of the stream from some mill, mine or tannery in the vicinity. This contamination not only kills fish, but it impairs the health of human beings. Dr. Dudley is right in voting for pure water. There is no use in attempting to bring about this correction between Philadelphia and Norristown. The foundation and sources of the trouble are at the heads of the small streams which empty into the Schuylkill.

Regarding the registration of deaths, I am glad that Dr. Dudley has brought up this subject. I think every person should be properly registered, and physicians should be responsible for the health of those in their communities.

Isaac Crowther, M.D.: I am glad the writer has recommended State control of running streams. All streams, large or small, especially those forming the boundaries between cities and boroughs, can only be kept free from pollution and contamination by a State law. We have on the southern bor-

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der of the city of Chester a little stream or brooklet, Lamokin Run, into which for years the two principal sewers of the borough of South Chester have emptied. The source of the contamination is patent, but there it remains, a stinking, reeking, rotting, sluggish pool. The Chester Board of Health has brought legal action against the South Chester authorities to abate the nuisance, but so far has not succeeded. The delays of the law are many, and a populous district has to endure the filthy and dangerous thing. By all means let there be a State law enacted forbidding the pollution of running streams. Until then, such large and important streams as the Susquehanna and the Schuylkill will continue to be the recipients of vast amounts of filth and contagion.

A. P. Bowie, M.D.: After listening to the able address of Dr. Dudley, I wish to say that I now think he made a mistake in reading his paper first. I would have liked to have seen the room full of Pennsylvania people to hear his paper read. We are passing through a campaign of education. I think we need a campaign of sanitation. In the place where I live, in the southwestern part of Pennsylvania, it is hard to get men of intelligence to pay the least attention to sanitary matters. In fact, we have been working for years to get a local board of health. We succeeded so little in our efforts to bring this about that it was only after threatening to place the matter in the hands of the District Attorney that we finally accomplished it. I think that this paper should be printed and sent broadcast throughout the State to show the importance of sanitary matters. We hear a good deal nowadays about gold and silver, but I think the sanitation of our State is of more importance than either of these subjects.

Hugh Pitcairn, M.D.: One of the difficulties in the way of procuring a pure water supply in the State, especially as regards the Susquehanna River, is the presence in Harrisburg of too many men who are interested in mining and tannery operations. At Harrisburg they have been extending the inflow-pipes farther and farther out in the river Susquehanna, until now they are in the middle of the river. I wish I could show you a bottle of water taken from that stream. After settling

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for awhile there would be one inch of culm in the bottom of the bottle. There are parties living along the banks of the Susquehanna, opposite Harrisburg, who for years have been getting from the bed of the river their supply of coal, which has been washed down from a distance of one hundred miles.

F. W. BURLINGAME, M.D.: I feel interested in the paper of Dr. Dudley, and have listened carefully to the remarks that have been made. In regard to the remarks about "inky water," I would say that the people of my city are the victims of either poor sanitary laws or laxity of enforcement. I have drank ink from the Youghiogheny River until I feel like an ink fount. Several miles above us there are tanneries that empty their vats into the river. Then all the water and sulphur from the hundreds of mines that are ranged along its banks empty themselves into the same stream. Fish cannot live in it. It only takes a few months for the water to make a sieve out of boilers or iron pipes. Yet we poor mortals are expected to drink it, and do drink it, to a certain extent. Is it any wonder that the distilling business thrives in the Monongahela Valley? There certainly should be decided action taken to influence legislation to the extent that something will be done to stop the pollution of our streams.

Z. T. MILLER, M.D.: I do not know of any process quite equal to that just spoken of which will turn water into ink. It has always seemed to me that city sanitation is pretty much of a fraud. This is a broad statement to make, but when you take into consideration that the city will expend annually hundreds of thousands of dollars for the purpose of creating some sewage apparatus or the putting of a proper slope in some pipe for impure water to run in to be churned up into a palatable (?) drink, is it a wonder we make such a broad statement? If that is city sanitation, the sooner it is done away with the better. It is a mistake, however, to lay too much stress upon the carrying away of disease germs through such an avenue. I do not believe that the drinking of that water has as much to do with the causation of disease as we think. I have been drinking the ink referred to by Dr. Burlingame for years past, and I was never so healthy in my life. We have all the refuse of our

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manufactories, stables, and what-not churned up and mixed into a big bowl of soup. Something has not yet been reached in the sanitary question. There are some other factors besides the water we drink that has to do with the causation of disease. Diphtheria is not so frequent as it was twenty years ago, and of small-pox we do not have many cases. Now, what is the matter?

SANITARY NOTES AND QUESTIONS.

BUSHROD W. JAMES, A.M., M.D., PHILADELPHIA.

1. Do invalids receive a sufficient amount of benefit from visiting distant health-resorts to overbalance the disadvantage of fatigue, exposure, inclemency of weather, travel discomforts, inferior accommodations and rooms, difficulty of obtaining unbiassed sanitary and medical advice, and the absence of all the pleasant associations and dainty comforts of home?

2. Would it not be advisable for tubercular cases with limited means to go to hospitals for the treatment of pulmonary diseases instead of taking long journeys, absenting themselves from all home associations and ties? Would not the treatment and recuperation in the hospital be aided by the patient's knowledge of his nearness to home and friends, and the trust that he might return to them quickly if he so desired? This very assurance should make him or her more patient and cheerful, and increase the reactive power of the whole nervous system.

3. Professor Robert Koch states that consumptive subjects should find suitable sanitaria near their homes. They should seek a place surrounded with a pure aseptic atmosphere and good medical attendance, and settle in such a spot, whether the location is high or not—giving, as his authority, the statement that tuberculosis is as prevalent in the Jura Mountains, at a height of 3500 feet, as in the city of Berlin. Does this not go

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to prove that a pure atmospheric condition at home or abroad is an extremely important factor in treating consumptive cases?

4. Dr. Claude Wilson writes in favor of mountaineering, with the grand proviso that its dangers shall be realized and avoided. He tells the tourist to eat freely while ascending the heights, but to drink sparingly in the meantime, and to avoid glacier water. Those who travel either for health or pleasure should be quite certain that they possess no disease of the heart or other organ upon which either the rarefied air or the undue exertion acts deleteriously. The possible too great purity or absence of earthy salts in the water, even though it flows from a great height or is congealed in the clouds in its purest form, is to be remembered by mountain tourists, for fear of injury thereby.

5. I do not think altitude in itself is a necessary condition for the cure of lung diseases. Some medical writers claim such to be the case, while others prefer flat pine regions for their patients, while others will prefer the sea-coast or an ocean voyage, and some a locality distant from the ocean. Is it not the ozonic purity of the air that is beneficial in any and all of these cases?

Elaborate and well-understood scientific measures that can bring almost any or perhaps all the requisite conditions together for the cure of these climatic diseases will no doubt sooner or later be brought about.

6. Is simply damp air always derogatory to health or to recovery, or is it not rather the decomposition of the animal and vegetable matter, and the generation and development of disease germs that is superinduced by the moisture and warmth, that is at fault? If we could obtain an even, soft, moist atmosphere, without the miasmatic exhalations of decaying vegetation, would it not be the ideal climate for certain non-hæmorrhagic advanced cases?

7. The best way to diminish disease is to prevent or avoid it. Therefore, to prevent tuberculosis, forbid the use of the meat of diseased or suspected tubercular cattle, or even of those which are liable to hereditary taint in calves. Use only pure milk and butter and cheese from cows which are known to be en-

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tirely free from any taint by the test for tuberculosis. Such a course, universally adopted, should eventually largely diminish this disease, not only in kine, but in the human system.

8. Would it not be a noble innovation to accept only meat of tested and non-afflicted cattle that are slaughtered near to their grazing-places? By this means the animals would be neither overheated nor irritated by driving, long confinement, hunger, thirst or fright; nor would the wholesale marketing of miscellaneous meats from animals that have not been proven healthy be continued at the risk of all susceptible members of the community.

9. Canned goods may be dangerous for several reasons. They may have been prepared carelessly; persons with tubercular or cutaneous or other objectionable diseases may have handled them; the cans may have been used previously; or the lead used in soldering may be exposed to the action of acids. Would it not be a good idea for the public to demand the use of glass or stoneware in the preservation of goods, or at least to compel all who engage in the canning business to submit to inspection the cans to be used, and to exclude any one from their employ who is in the least affected with cutaneous eruptions or any objectionable disease? Are not pure, clean and perfectly tinned cans safe if only the best fruits and meats are used, and if the sealing-solder is not exposed to the inclosed juices? To support this idea, goods canned at home by careful cooks are seldom or never known to poison.

10. Special attention must always be paid to the water supply, either for drinking or cooking. If the water is found to be influenced by any poisonous matter it must be corrected immediately, or the use of the water be discontinued. All springs, mineral or otherwise, should be covered in such manner as to prevent the dust, dried leaves or other débris from falling into them. They should be built up and around for a considerable distance above and below the outlet with tile, cement or granite. Marble, containing, as it does, a certain amount of calcareous material in its composition, could be so acted upon by some minerals as to make its general use improper; therefore its use in the receptacles of certain springs is to be carefully avoided.

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To render the use of spring waters perfectly safe, it should be drawn from spigots placed so as to receive the flow below the surface, and not deep enough to agitate the lower strata. Thus any floating matter would be avoided, as also would be any heavier mineral deposit. It should be a fact deeply impressed upon every individual, sick or well, that the waters from no medicinal spring whatever should be taken without the advice of a competent physician. The promiscuous drinking of such waters frequently produces serious derangements in apparently perfectly healthy individuals.

11. Is boiled water palatable and pure enough to drink? Or is there not equal danger from the ptomaines in boiled water, as from the microbes from unboiled water? When cisterns, tanks or other receptacles are used they should always be under cover, but easy of examination. The dust from the stables, from the rooms of sick persons, from dead animal or vegetable matter, contains the germs of numerous diseases that develop quickly in soft water. Then, too, there is great danger that the leaves from poisonous trees or vines will fall upon the water and swiftly communicate their toxic qualities to the fluid. Is not the necessary prevention absolute in this case?

12. As air is rapidly vitiated by respiration, several persons in one room must soon poison the atmosphere with carbonic acid and animal exhalations. Is it not, therefore, very requisite to have constant air-currents from the outside to supply the necessary pure air to keep the occupants in ordinary health? In such cases, is not the possibility of draft less important than the entrance of the fresh air? But drafts can be avoided. Is not the pure air, without draft, a fundamental agency in restoring and retaining health in both old and young?

13. Is smoke a disease-producer or carrier, or are its antitherapeutic effects due only to its irritating influences upon mucous surfaces? Is it possible for smoke to carry with it the toxic properties of the substances submitted to fire? I think it is. If fire thoroughly burns up all the substances, the poison also is destroyed; but smoke contains unburned particles, and, therefore, the effectual prevention of epidemic diseases that is claimed by burning may be deceptive, unless all the particles in the smoke are superheated.

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14. Proper and always effectual sewage being absolutely requisite to the full enjoyment of the health in cities, towns and homes, should it not always receive first consideration when one is selecting a residence-dwelling? And should not the authorities have plans of the plumbing and drainage and run of pipes, and then be compelled to give immediate attention to any obstruction in pipes, sewers and outlets? Is it not a great evil to allow the refuse taken from inlets, or the sweepings of the streets, to remain upon the highways for hours?

15. We believe in using thorough disinfection, and think it is a necessary aid to drug-action by perfect cleanliness. Ptomaines might otherwise still remain to continue the destroying power of disease, or to produce one of equal poisonous influence.

16. Is there any true and unquestionable manner of disinfecting rags from diseased ports except by steam heat? Would it not be a great deal better to entirely exclude such articles from commerce altogether, and especially from ports where diseases are likely to be carried by them and become epidemic?

17. Have isolation, exclusion from school, vaccination and all such treatments made quite satisfactory returns to compensate for the inconvenience, loss and expense of such requirements?

Are not school children in greater danger of contracting diseases in the street than in schools?

18. Does fright or over-anxiety have any influence in developing, or aid in, contracting epidemic diseases?

19. Has the human will any power whatever to prevent acute attacks of prevailing diseases?

Can the will power aid medicines in their action upon the system, or is the whole curative power vested in the drugs used?

20. Oftentimes sick people travel for pleasure into countries and climates entirely opposite to those in which they live, and greater illness, or debility, and sometimes even sudden death, ensues without appreciative cause. The reason probably is that organic defects or chronic disease may have been present, but not developed to a degree sufficient to cause anxiety until ac-

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climatization aroused up an acute aggravation. This leads to the establishment of the fact that no one should make too sudden a change, particularly in altitude or temperature.

If a physician recommends a patient to the mountains, he should qualify his prescription by prescribing slow stages until one becomes accustomed to the higher atmosphere. Does it not also show that no one should take such journeys without consulting his physician? If the consulted physician does not understand the effects of climate, should he not confess it and give his patient the opportunity of further advice?

HYGIENE.

IRWIN B. GILBERT, M.D., PHILADELPHIA.

From a few general rules and precepts, hygiene has developed into a science complementary, yet indispensable to the chemical branch of the department of medicine, and its domain consequently expands as the great science of medicine advances.

I do not deem it necessary to allude to the derivation or etymology of the term hygiene except to note the fact that Hygeia was the daughter of Æsculapius, thus even etymologically very fittingly and significantly linking our laws of sanitation with those of the healing art.

Although Hippocrates, in his wonderful writings, makes reference to hygienic rules even then in force, yet hygiene did not reach the dignity of a science until very recent times, due, in a large measure, to an ignorance of the laws of chemistry by those who professed to be the followers of this science.

Chemistry is the outgrowth of alchemy; and although the assumptions and pretensions of the followers of the latter art retarded the advance of knowledge in this and other lines of human progress, yet it is from the germ of truth contained in it that the science of chemistry has developed, until now it

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surpasses all other departments of knowledge in the absolute exactness and precision of its propositions and its demonstrations.

The discovery and demonstration of the properties of oxygen laid a true foundation for chemical science. The discovery of specific germs and the method of their destruction by chemical agencies is the basis of our modern sanitary science, and it has advanced to such a degree now, as exemplified by our State and local boards of health, that there will be no repetition of the devastating epidemics that almost depopulated countries during the Middle Ages, when no precautions were taken, and when all sanitary rules were violated.

Due to the voice and labor of medical men of all civilized countries, in this enlightened age there will be no more waste of human life through ignorance of the principles of hygienic laws, nor through want of legal right and authority to put into prompt effect sanitary measures necessary to the arrest and suppression of the *causes* of disease, as they have been demonstrated by bacteriological research and proof.

Great good has been accomplished by the original researches of earnest and competent investigators who have devoted time and labor to discover the most perfect means for the conservation of the health of our people, and many laws have been enacted to the same purpose; and these means for the general good of a community are brought into activity by the physician in his interpretation of them to his patient and to those under his charge, whom he is always ready to shield from threatening diseases, and to advise and instruct as to what hygienic measures should be used for the preservation of health; and all this work is done at the expense of his means of gaining a livelihood. Surely this is true philanthropy!

It is the distinct province and the duty of the doctor to instruct in and to disseminate correct knowledge of hygienic laws, and it is through him alone that the people of a community can or will be educated to a proper conception and to a full and true comprehension of the advantages that come to them by carrying out all proper municipal sanitary regulations. The progress of a town or city is judged by the efficiency

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of the sanitary measures employed for the protection of its people.

I will quote from the records of the city of Buffalo, N. Y., as a most striking exemplification of the workings of modern hygiene. With a population of about 375,000 inhabitants, the death-rate has declined from 23.48 to each one thousand of the population, for the year 1891, to 13.95 to the thousand for the year 1895. The death-rate of contagious diseases declined from 7.42 to 4.04. Over two hundred miles of asphalt pavements, an abundant supply of pure water from Lake Erie, the vigilance and efficiency of the Health Department, and the active co-operation of the physicians and the municipal authorities have brought about these truly wonderful and praiseworthy results. It also emphasizes the fact that there is no aspect of the question of sanitation that does not concern the medical practitioner.

As I have not been restricted to any specific application of the subject assigned to me I shall treat it discursively, and will not confine myself to any of the distinct departments of this great science of sanitation, but will simply touch upon, and give in outline, a few thoughts upon the three great subjects that are paramount in their importance, as they relate to the welfare of the people in the preservation of health and the prevention of disease.

Pure *air*, pure *food* and pure *water* are the essentials of good health, and it is to these that we shall give a few moments for consideration, speaking first of pure air. Surrounded by the ordinary environments, and living in the usual manner under which human beings congregate, we can make use of the expression pure air as a relative term, for it is never free from dust particles, and in many localities it contains the deleterious gases thrown off by industrial operations of many kinds. Mingled with these are the emanations from the soil, from the gutters and the surfaces of the streets, from whose unhealthful influence there is no escape. It is also the medium of dissemination of disease germs and of bacteria, both harmless and harmful. It is alone through forces inherent in the human organism that these hurtful agencies are held in abey-

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ance or defeated, and under their protecting influence the normal functions of the physical economy are carried on undisturbed in the ordinary condition of health.

The need of ventilation by the free access of light and air to the dwelling is self-evident, as taught by the knowledge of the changes that are produced in the surrounding air by the function of respiration, and by the exhalations from the human body even under normal conditions.

Cleanliness and the free admission of air to the different apartments of the house are all that is required to render them healthful; but when the air and contents of the dwelling become infected with disease germs, it is then by the use of disinfectants alone that it can be rendered safely habitable.

All disinfectants are oxidizing or reducing agents, and the chemical action that takes place is readily explained by well-known chemical laws. Nature acts on a grand scale by the discharge of powerful electrical currents through the air. These change the oxygen into a more active form that is known under the name of ozone, or O_3.

This is one of the strongest and most active oxidizing agents, and is now produced by means of electric currents for the purpose of purifying the air of school-rooms and other large buildings. It will destroy all noxious principles in infected dwellings.

Hydrogen dioxide, so largely used now for antiseptic properties, resembles ozone very closely in its chemical properties and action, and, like it, acts by its oxidizing power, giving up its extra equivalent of oxygen, and reverting again from H_2O_2 to common water, H_2O. Chlorine acts in a similar manner, and is a gas of great activity and efficiency.

Burning sulphur will take up two equivalents of oxygen from moist air, and becomes one of the most familiar of the disinfecting, germ- and effluvia-destroying gases under the name of sulphur dioxide. It has a wide range of applicability, and is more frequently employed than any of the others mentioned, owing to its cheapness and the ease with which it is prepared and applied.

Pure water, as a source of good health, is more emphatically

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recognized, now that impure water and typhoid fever sustain the relation of cause and effect. In our own city, the question of an abundant supply of water is one of the most urgent and most important that confronts, and demands attention from the citizens, the health and the municipal authorities. Whence this supply shall come concerns the municipality and its engineers; but the need is urgent, and it is incumbent upon every physician to urge the necessity for prompt action, that the good health of our people may no longer be endangered from this source. Great advances have been made in the prevention of disease by the recognition of drinking-water as a source of infection. The spread of cholera has been traced to this same source of dissemination, as evidenced in the epidemic of this disease in German cities a few years ago. At the same time the effectiveness of proper filtration and purifying methods was also demonstrated by the freedom of the city of London from invasion by the same epidemic, although no quarantine was established, nor were the channels of trade interfered with to any extent beyond prudent precautionary measures. The source of supply is the river Thames, a stream of foul water.

Pure food is palpably an essential of good health, but food is not, like water, a propagator of disease. The ingestion of improper or deleterious food may interfere with or derange some of the functions of the body. It may be of an indigestible nature, and may cause a train of symptoms to follow the introduction of it into the stomach. Granting the needed intelligence, the selection of food is a matter of discretion. Unripe fruit is intuitively rejected. Taint in animal substance is readily detected. With cleanliness and care in the selection of the one class of food, and with the use of the proper degree of heat in the preparation of the other, under ordinary conditions, good health will be preserved.

I do not wish to touch upon the great and important subject of dietetics, so closely related to preventive medicine, nor do I desire to pass it over with a few dogmatic assertions relative to the proper kind of food for daily use. The quality of the food is usually assured; the healthfulness of it is dependent upon its manner of preparation for the table. The question of the spread of epidemic diseases is one of water, not of food.

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Humanity will never reach that ideal state when disease shall cease to exist. The dietetic art will never attain the perfection necessary to maintain infallibly the equilibrium between waste and repair. The toxins, even to the most enthusiastic visionary, will never render the human body immune and impervious to the poisonous germs of contagious diseases. Admitting all, we still know that in the line of prophylaxis is where the doctor finds his highest reward in the consciousness of unselfish labor.

THE NECESSITY OF DISINFECTING SPUTA.

A. W. BAILY, M.D., ATLANTIC CITY, N. J.

Upon the respiratory mucous membrane a number of diseases, more or less serious in character, first make their appearance, and it is through the agency of this membrane, more especially that lining the upper air-passages, that these diseases find an entrance into the system. The mouth, including the nose, which is simply a superior inlet, in so far as it relates to this paper, seems to be a receptacle for catching and holding any disease-bearing microbes which may find an entrance with food or drink, by inspiration, by kissing, especially upon the lips, or by the vicious habit many persons have of using the mouth and lips for holding small articles, as money, strings, pen, pencil, pins, etc.

The mucous membrane lining this cavity is especially adapted for arresting and holding foreign matter, and not only are disease germs caught and detained in its folds, but far too often do they find here the pabulum necessary for their development and reproduction. By any irritation of this membrane, such as can be readily produced by sudden changes in temperature, especially from heat to cold, or by rapid variations in humidity, by a bad condition of the teeth, or a disordered stomach, or even a simple neglect to keep the mouth cleansed, the follicles become congested and often hypertrophied, and their normal secretions are so deranged and altered in character that they

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may become culture-fluids for the various forms of bacteria which find a lodgment in the mouth.

A study of the anatomy of the tonsils will leave but little doubt that, no matter what their special office may be, these glands play a very important part, not only in supplying a nest wherein bacteria may thrive, but are also active in introducing these disease-bearing germs into the system. These glands are masses of lymphoid tissue, with from six to a dozen orifices leading into blind pouches or sacks. These pouches or crypts are more or less filled with a substance composed of fat molecules, lymph corpuscles, epithelium of the pavement variety and cholesterin crystals. This lymphoid tissue, which is so abundantly found in the faucial region, is but a part of a wall or chain of similar tissue that guards the nasal and oral openings to the pharynx and larynx. This tissue extends across the base of the tongue, is found in the side walls of the oro- and naso-pharynx, extending to the vault, where it is again more abundant, forming the tonsil of Luschka, and is in such intimate relation with a large arterial supply that buccal secretions and such elements of food and drink with which it may come in contact can be readily absorbed, and through this function this lymphoid tissue becomes a channel giving great opportunity for bacteria or other deleterious matter to enter the general circulation. We can, therefore, safely concede the absorbent function of the tonsils.

Among the diseases which can the more readily be contracted through the mucous membrane of the mouth may be mentioned pertussis, tuberculosis, diphtheria, membranous croup, parotiditis, pneumonia, such eruptive fevers as scarlatina and measles, tonsilitis, pharyngitis, and perhaps some forms of catarrh. All of these produce more or less disturbance or destruction of the mucous membrane, with consequent throwing off of effete material, and it is but reasonable that these unhealthy excretions, with their accompanying bacteria, should infect any healthy individual in whom they find a suitable soil for reproduction and development.

Care, then, should be taken of the sputa of patients suffering from any disease the germ of which may be found in the

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substance expectorated from the mouth or discharged from the nose. In hospital practice it may not be difficult to secure the necessary disinfection, but in private practice, especially if the patient is not sufficiently ill to be confined to bed, or to a room, it is extremely difficult to secure proper disinfection of sputa; and particularly is this the difficulty encountered in cases of tuberculosis and whooping-cough. In scarlet fever and diphtheria, or in any disease of the nose or pharynx that the physician may call by that much-abused term, "diphtheritic," usually all the sanitary measures that are necessary or may be suggested are willingly employed, for the laity have a wholesome dread of these diseases. But in other diseases the willingness to employ faithfully the necessary sanitary precautions is lacking, and, if used at all, it is usually in a half-hearted manner.

The one great point regarding the spread of whooping-cough in a family or neighborhood, that needs to be thoroughly impressed upon the laity, is that dried sputa conveys the disease, and, except in the presence of abundance of fresh air, the dust rising from this sputa is highly contagious. All discharges from these patients, whether vomited or expectorated, should be thoroughly disinfected before allowed to become dry. The method employed, provided it is effective, is not so important as the thoroughness with which it is carried out. Boiling hot water, or bichloride of mercury, 1 to 1000, or Labarraque solution are the disinfectants I usually recommend. If the child has expectorated into a vessel, the disinfectant should be used before the vessel is emptied. If the carpet or the floor has been the recipient of the vomit or expectoration, as is often the case with young children, it should immediately be scrubbed with a boiling-hot solution of bichloride of mercury, 1 to 1000. Rags or towels that have been used, especially at night, should not be allowed to dry, but thrown into a vessel containing a disinfectant, and there kept until they can be properly cared for. Many children, especially during the warmer months of the year, are encouraged to go into the yard when a paroxysm of coughing comes on, and expectorate upon the ground. This is a sure way to contaminate a neighborhood, and should be discouraged.

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By care and frequently cleansing the mouths of the other children who may come in contact with the patient I have succeeded in confining whooping-cough to one or two children in a household, and that without isolating the patient.

What has been said regarding whooping-cough applies in even a greater degree to tuberculosis, because of its more serious nature. Tubercular infection of tissue means tubercle bacilli and their product in all excretions or sloughs from the parts affected. Sputa are loaded with these bacilli, and when dried and converted into dust the poison-bearing particles are carried by the air everywhere, and if they alight on a suitable soil the result will be contagion. Every tuberculous patient should be taught that he is a menace to the health and life of the other members of his family, his friends, and, in fact, in a degree, to the community in which he lives. When possible he should eject his expectoration upon small pieces of cloth, which should at once be deposited in a closed bag or pocket-case, and burned before becoming dry. This is the safest and most convenient method while walking upon the street or travelling. The bag should be lined with rubber tissue that can be thoroughly disinfected. Cups made of pasteboard may be used. They should be covered to prevent the entrance of flies, which will carry off on their legs or in their intestines quantities of bacteria. A cup should not be used longer than twelve hours, and then burned, with its contents.

In disinfecting it is not sufficient to pour boiling water over tubercular sputa; rags, towels or whatever has received the sputa must be immersed in the water and boiled. A strong bichloride of mercury or Labarraque's solution may be used, but I prefer a 10 per cent. solution of lysol, as it not only is a thorough disinfectant, but also has a tendency to liquefy the sputa, and thus is more sure of reaching the bacteria in the thick, heavy masses that are often discharged by consumptives. It must be remembered that a solution becomes weakened by the addition of sputa, and a sufficient strength must be allowed to overcome this dilution. It is not sufficient that sputa be immediately emptied into the sewer without disinfection, for

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the bacillus of tuberculosis is long-lived, having been found viable in the body of a consumptive two years after death.

The secretions of the mouth, as well as the expectorations of consumptives, are dangerous. I have found the bacilli of tuberculosis on the tooth-brush of a consumptive. How often do the members of a family keep their tooth-brushes in the same holder or tray, and what is easier than for the contaminated one to infect the others, and thus, through a simple abrasion of the mucous membrane of the gums or mouth, communicate the contagion to a healthy individual?

It seems to me we cannot too strongly impress upon our patients who may have an infected expectoration the responsibility that rests upon them to prevent, so far as possible, any extension of their disease to others. A long step in the right direction has been taken by our street-car companies, and other corporations that carry passengers, in prohibiting that filthy and disease-breeding habit of spitting upon the floor. Cuspidors have long been provided in public buildings, but they do not receive proper attention. They should never be filled with sand or sawdust, as these tend to dry the sputa, but they should be about a third filled with water. Before being emptied the contents of the cuspidor should be thoroughly disinfected; the cuspidor should then be carefully washed. It would be better if the water put into the cuspidor, while in use, was a solution of some disinfectant, for thus the contents that it may receive during the day, from the half-smoked cigarette of the athlete to the disease-laden sputa of the consumptive, will be rendered inert. In construction the cuspidor should be so made that it will not upset, that it can be thoroughly and easily cleansed, and will hide from view, as far as possible, its unsightly contents. It should be made of non-porous material, and never allowed to stand in the sunshine while in use.

There are other methods of carrying these contagious secretions and excretions, such as the public drinking-cup, and the single cup used at the communion services of a vast majority of our churches; and there are other diseases, such as cancer and syphilis, which produce a virus that will infect a healthy

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individual if it reaches an abraded surface, but these hardly come under the scope of this paper. If our patients can be taught the responsibility that is resting upon them not to endanger their families or friends, an advance step will be taken in controlling in a rational manner the extension of many diseases that produce infected sputa.

A NEW METHOD OF PRESERVING AND STERILIZING LIQUIDS.

BY L. PRICE RANDALL.

Mr. President and Gentlemen:

It is my privilege to bring before the members of the Homœopathic Medical Society of Pennsylvania a process for the sterilization and preservation of foods and fermentable liquids, the bearings of which are so far-reaching and of such practical every-day importance as to warrant the careful attention of all thoughtful physicians.

The method of sterilization introduced through the labors of Appert and Pasteur, and commonly spoken of as "Pasteurization," has without doubt brought enormous benefit to mankind. Practically, fresh vegetable food has brought exemption to the seafaring man and the soldier in garrison from that terrible scourge, scurvy, while the tables of both rich and poor alike have been supplied at all seasons with most acceptable substitutes for the dried meats, fruits and vegetables with which our grandparents were forced to be content.

Notwithstanding the benefits which have accrued to all classes from sterilization by heat, there are certain drawbacks to the system which for years refused to give way before the experiments of the scientist.

In no case can cooked fruits compare with the fresh articles, and all methods hitherto employed for the preservation of milk have rendered it distasteful, poorly tolerated by many stomachs, and a very indifferent substitute for fresh milk; and malt ex-

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tracts, as to-day offered to the invalid, are, according to the analyses of Leffmann and others, strongly alcoholic or preserved from fermentation by means of deleterious acids or proprietary compounds. They are, in fact, either porters or brown stouts of a higher percentage of alcohol than the genuine articles, or they are rendered dangerous by adulteration.

This is also true of the so-called "unfermented" wines offered for medicinal or sacramental purposes.

There has been recently developed a process which will place within the reach of all fruits and fruit juices, milk, malt extracts and other food-products in a condition possessing all the qualities of the fresh article. This process is based upon the researches of the eminent French physiologists, Paul Bert and D'Arsonval. It consists essentially in the exhaustion of the contained air and the substitution of a highly compressed atmosphere of pure requirements of the materials to be treated.

It was fully demonstrated by these well-known authorities, before the French Academy, that organic matters of all kinds could be preserved indefinitely, and without deterioration in taste, odor, appearance or other respects, by high pressures of the gases mentioned.

A laboratory experiment as performed by the skilled investigator is, however, a very different matter from the adaptation of his method to commercial purposes.

After repeated trials the method used by Bert and D'Arsonval has been brought to a practical state through the designing of special apparatus, and the process of preservation by this means can now be seen at No. 628 Race Street, in this city, and the medical profession is especially invited to examine into its merits. One peculiar feature which will be of great interest to the practitioner is the application of this process to cod-liver oil. It is probably well known by most of those present that the superiority of certain brands of cod-liver oil is due to the oil being expressed and refined in an atmosphere of carbonic acid gas, rapid oxidation of the fats and the formation of ptomaines being thus prevented. Unfortunately the value of this process is not lasting after the original package has been

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opened, and even the most palatable of this "new method" oil becomes rancid and unpalatable soon after exposure to air.

The method of the Universal Food and Liquid Improving Company has the great advantage that the oil can be treated and delivered in siphon bottles, from which it can be used from day to day to the last drop without undergoing the slightest deterioration, while the carbonic acid with which it is saturated renders it capable of assimilation by the most delicate stomach. A very pleasant surprise is in store for those of you who have not examined the process, when you find how really palatable cod-liver oil is when treated by this method.

Carbonated waters have long been held in high esteem by the profession, and in the shape of Apollinaris or other effervescent waters have come to be almost a necessity on the tables of the wealthy classes. The process to which we have invited your attention brings within the reach of all classes absolutely pure water, possessing a higher degree of effervescence than has ever been effected by any other process, and excelling all carbonated waters, natural or prepared. The limited time at my disposal forbids my entering into more details concerning this method and its manifold applications, but I have the pleasure, through the courtesy of your Officers, to be able to invite you to a personal investigation in the lunch-room below stairs of some of the products treated by this process.

Gentlemen, I thank you for your kind attention, and for the privilege of bringing this subject before you.

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REPORT OF THE BUREAU OF CLINICAL MEDICINE.

The Middle of the Road in Medicine, by Z. T. Miller, M.D.
A Study of Albuminuria and Urea, by Edwin H. Wolcott, M.D.
On the Importance of Mental Symptoms in the Selection of the Remedy for the Sick, by A. P. Bowie, M.D.
On the Danger of Neglecting Bronchites, by Edward R. Snader, M.D.
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THE MIDDLE OF THE ROAD.

Z. T. MILLER, M.D., PITTSBURG.

My Democratic friends, my Republican friends, will pardon me for injecting into this paper a bit of the Populistic creed. The title seems so *apropos*, and the subject upon which I write so well epitomized by the text, that no other title could possibly express, in so few words, the exact duty of every homœopathic doctor. *Homœopathy* is the "Middle of the Road;" its standard is *truth*, first, and plenty of gold and silver afterward, no matter what the ratio. It is to be congratulated that no machinery manipulates its formulæ; no chicanery distorts its platform, and selfishness can never add to or take from its prestige of one hundred or more years. Bolters from the convention sink into the oblivion of the outcast; and nothing save a charity 'kin to that bestowed upon the prodigal son can reinstate them to the fold and fatten them from an attenuation of a

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diet of husks. The "Middle of the Road," then, marks a line hither from the earliest enunciation of its principles, and leads back, as well, to an epoch in human affairs when the psychic forces, so-called, gave birth to principles and man, whose attributes are well nigh immortal. I need not mention the many, to you, familiar examples that illustrate the truth that when a step forward in the progress of the all-governing, unavoidable momentum of evolution is to be taken, men rise who become the enunciators of the new and destroyers of the old. Nor need I tell you what that step was or who the man who took it. Much less need I tell you that the impress of his feet has not been found anywhere in the succeeding march of medical history but in the "Middle of the Road," neither turning to right here nor to left there as an idle whim of substitution presented itself. The law that was to mark an era in medical events burst upon the miserable pretensions that marred mankind, and a man, whose courage was as colossal as the might of a Samson, pulled down the pillars of a mighty temple of deceit and built upon its ruins that which was and is adapted to the needs, mental and physical, of men, mothers and babes. Such discoveries and such men are not errors; they are evolved from the inner consciousness of an unmistaking and ever-unfolding nature, and have the impress of the finger of God.

The persistence of a conviction that faltered not from its inception; that carried to completion, in logical sequence, the various records of its progressions; that battled for and maintained the declaration of its supremacy until its opponents acknowledged the right of the decree, while its friends proclaimed a loyal allegiance because of their love of the gentle and hatred of the barbarous, could have accomplished the stupendous work achieved in no other way than by keeping to the "Middle of the Road."

The faith that moves mountains is potent for great good or great evil; fortunately, the faith of our prophet was for great good; and that he held to the median line accounts for the mountains that have been moved and the multitudes that have been mastered.

He announced the fact, and stood to it as of divine appoint-

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ment, being unalterably convinced of the truth himself. He evinced character requisite for the moulding of new methods, and possessed the force that compelled acceptance. So well was the work done that not one of his followers need step aside. The foundation and superstructure descended to them an inheritance without a codicil, a habitation in appointment complete.

The one command of the sage of similia was: Keep to the "middle of the road." He himself saw no occasion to depart from the line, and, having drawn it, illuminated it, placed it conspicuously before the men most interested, had a right to expect that those who accepted the directions would follow them and stay in the "middle of the road."

It has been said of me that I am entertaining, but not instructive. I have heard of damnation by faint praise. That criticism seems to me to be about as near an approach to the results accredited faint praise as could be without calling the aid of the instigator of the remark. Be that as it may, as betwixt being interesting and uninstructive, or *neither* instructive nor interesting, I prefer the former as having at least a semblance of usefulness. Perhaps I was assigned this bureau because the chairman agrees with me that it is possible to be interesting if not instructive. Indeed, I know of no department of medicine wherein it is possible to be so interesting and at the same time well-nigh impossible to be instructive; where so much can be and is said; where so little absolutely trustworthy instruction is imparted. The very nature of the evidence, its source, its possible contamination, its toning to meet the requirements of the occasion, its lack of basic judgment, all combine to o'ercast it with a pall of uncertainty that shows at once that the "middle of the road" has been strayed from.

It requires a level head to be a deductive clinician. It's possible to be a good doctor, but a thunderin' poor reporter of clinical cases. It's possible to be a good prescriber, but one needs to be a Mahatma, or some kind of a theosophical thing, to know just whether he is the only one meddling in the case.

Now, I would not cast a shadow of doubt upon the reports

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of any man. Yet my own critic hesitates not to say "they lie" when a marvellous cure of some poor sinner or saint that has been respited for their respective future abodes is mentioned. The man who reports well of cases by the cm. potency is a "liar" in the judgment of the man who never has, and by the devils never will, go higher than the 3x. The cm. man, with a contempt quite as emphatic, brands his brother of the 3x proclivities as some kind of an animal whose father and mother did not belong to the same species, and, to be brief in sentence, hisses 'twixt his nither, nathur or neether incisors, *Mongrel.*

Of course, you will recognize at once the beautiful harmony and angelic simplicity that lurks in the "souls" with but a single thought. The Montagues and Capulets of medicine, with their Tybalts and Mercutios, need something more than the sickly Romeos and sicklier Juliets to keep them in the "Middle of the Road." The houses will not be joined and preserved from disintegration by internal strife if they do not "come off the perch" and not go round with sword dangling between their legs ready to disembowel the villain who dares to say cm. or 3x.

I am afraid some of us will exclaim, "Where is the 'middle of the road?'" I answer, so far as homœopathy is concerned, it is *Similia Similibus Curanter.* You need not stop to argue whether you spell the third word with an *u* or an *e*, but go right ahead, applying the symptoms of the provings, as represented in the drug, to the symptoms of the sick as represented by disease. That's the "middle of the road;" "und Hier steh Ich, Ich kann nicht anders."

There is a field for clinical observation that has been but poorly worked, one from which much valuable information can be obtained if the crop is more than indifferently attended. For instance. A well-put-up job of recovery while the cm. potency was being administered, is brought to your notice. Your 3x man, who believes such reports are false as to the *cause* of recovery will hardly question the *fact* of recovery, since the fact is capable of demonstration. Admitting as much, you may learn that it is possible for a very sick man to recover while

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taking the cm. potency or *no* medicine, as you will. This knowledge will stand you in assuring confidence when you meet a similar case, even though you treat it after your own method. If your patient gets well also, you *may* argue that the medicine cured him, for you *know* medicine was given. You may argue so in spite of the fact that you have just learned that such a case can recover *without* medicine, and I know of nobody who can say you nay. What if the patient dies for both my cm. and 3x friend? It were a work of supererogation to recount the argument of my cm. brother, who views with the greatest possible concern the growing tendency on the part of some people to kill others. While my architectural knowledge fails entirely in an attempt to describe the curve that curls the upper lip of my other, the 3x friend, as he contemplates the soullessness of allowing anybody to die without medicine, how plain is it to be seen that neither of these friends is in the "middle of the road."

This business of medicine is a peculiar business. It admits of extremes and happy means; at least it seems so to me. In my own experience I have seen moonshines accomplish that which the crudes seemed incapable of, and *vice versa*. I have also seen the middle ground yield an equally abundant harvest. As yet I have not been able to formulate a rule for the adoption of either scale. In running this gamut I feel that I am strictly in the "middle of the road," so long as like symptoms are pitted against each other. I am no less in the middle if I allow my patient the full benefit of his own recuperative resources. Of one thing I am unalterably convinced, and that is, it's better to *stay out* when you have not a full hand. The practice of giving something for the sake of giving, or giving it because you don't know of anything better to give, is rot. You couldn't get further from the middle—unless you give two. I think I would as lief be a foot-ball in the hands of the craziest Padarewski, middle-parted mob as to have my vitality kicked around for the fun of it.

The clinical man is the one made up of distinct properties. He has perception quite characteristic. Sees things from an angle other than the man with a knife. He embodies two

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qualities, the observant and constructive. No one can be a successful clinician without them. To observe your subject, and from that observation construct a form that stands out bold to be measured for the curative clothes, constitutes his work.

It is hardly necessary for me to state what is required to qualify one for the task just mentioned. A knowledge of disease, also a knowledge of materia medica, you suggest at once, but there is something else—a formative mind. Imagination is not the thing, although at first sight it would seem to be.

A formative mind grasps suggestion. Suggestions are the symptoms of the patient as subjectively and objectively expressed, *and* the written language of the materia medica. The suggestions from the two sources are built and rebuilt until the structures are as nearly alike as it is possible for them to be when there materializes the forms of similia. The mechanical mind does not seem to me to be equal to the occasion, but is quite and eminently adapted to the sanguinary part of the medical art.

The reason some men are unable to make head or tail of materia medica is, no doubt, due to the fact that the words they read are not supplemented by the constructive element of mentality. The beginning is forgotten before the ending. Hahnemann must have recognized this feature of his possible disciples and met it by a strict command to note the symptoms of the patient at the bedside.

The man who reads but does not listen to his words is as blind to the intent of his lesson as is the sightless man to the beauties of a sunset. If by the time he has finished the symptomatology of a drug, his mind has not been impressed by a picture of its effects so vivid and accurate that it can be thrown upon a screen for him to look at, then the time spent in the reading has been lost, lost because he has not taken his notes this time by the bookside. The same is true of observations on the patient.

This process of observation and notation need not obtain in every case. When in our mind's judgment we can safely trust a case to that kindly recuperative force *vis medicatrix naturæ*, the intricacies of the problem need not be applied. Only the

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severe and death-tending or the persistently chronic diseases raise to the dignity of such consideration.

Some men can talk, some men can think. When the men who talk and the men who think join their forces, good may come, provided they think the truth and speak the truth. The time is ever propitious for such utterance; but none more so than when the questions that come nearest the welfare of the people are being discussed. The responsibility of the educator must not be underestimated, nor must the sovereign self of each individual be measured at one fraction of an inch less or weighed at one atom of weight less than it stands for in this land of men among men. The educator must know that the men whom he seeks to educate are themselves educated; that they listen, not because they learn something, but because they hear familiar things, and familiar utterances are always welcome utterances. These thoughts occur to me as eminently applicable in summing up the attitude and relative importance of the medical and surgical branches of our profession. The man who wields the power of a definite knowledge of materia medica and the man who commands the absolute force of the knife are as indispensable, the one to the other, as are the + and — terms in electric subtlety. The scope of their respective labors is fast drawing a line of limitation beyond which neither cares to poach. How futile it would be for the one to essay the total sum of knowledge when those they address are themselves educated. When, however, they combine their knowledge and exercise their powers in the highest development of art, the marvels materialize and the blessings of the miserable and maimed made whole do follow them.

One thing this combination, so potent for good, must do is to stay in the "middle of the road," and, as I have said before, that "middle" is homœopathy. In the medical art every requirement is fulfilled, while no part of surgical technique but that can be most happily supplemented by it. Its resources are equal to the uttermost demands, thus rendering negative the necessity for such miserable makeshifts as brands us insincere in our profession. The world over, the greatest achievements are wrought by the simplest means. In no way is ho-

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mœopathy an exception. Her experience is pregnant with the children of her conception, and her literature an unending record of the labors that have brought forth the fruition of her mighty truths. The pride of every man who musters under her banner should forever forbid that his footsteps should leave their prints anywhere save that middle ground where trod the master, followed by a host of men upon whose day the sun of similia never sets. Hering, whose memory is yet green, whose labors lightened yours, whose perceptions broadened the vision of all who followed him; and Lippe, that brave, uncompromising defender of the faith, he whose combativeness faltered not, whose sword knew no scabbard so long as his convictions were assailed; and Guernsey, than whom none have more carefully, tersely, succinctly handed to his successors the secrets of his own achievements; and Farrington, the sound of whose name awakens in the mind of many of you an association when the rôle of least before the greatest was your respective parts in the drama of materia medica, a man whom gentle earnestness and thorough devotion to *his* calling and *your* advancement made him a memory wreathed with immortal gratitude. What one of you that has not been taught by one or more of the men who bore the illustrious names just mentioned?

The modesty of the living forbids mention of the many no less famous, whose daily work and successes show them clothed with the mantles of inheritance. *Whence the source of all this?* What the inspiration that started it? What the rock smitten by the God-gifted hand of the *sage*, from whose cleft sprang a crystal, rippling water, more potent to heal than the liquid of Lourdes ever was or ever will be, notwithstanding its Virgin maternity? The answer is not in the stars, but in such monuments as this—*The Hahnemannian*, of Philadelphia—supplemented by the many similar that dot this great homœopathic land of ours. The murmurings of another answer are being heard. Men whose lives have been brightened, whose usefulness has been heightened, are determined that the sun of their gratitude shall shine upon the form and feature of the man who stood for them. Even though the eyes be dead to sight, the ears dumb to sound, the lips speechless to acknowledge, yet

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will the marble and bronze proclaim to the whole world that the voice of a hundred years ago is echoing loud, long and distinct across the waters and against the hills and hearts of a country in whose freedom his wisdom met its most cordial acceptance.

Fitting place and fitting time this, fitting men and women here, who, hand in hand, neither looking to the right nor to the left, lift their faces to the light of truth and bless the name of Hahnemann, its source, by keeping in the "middle of the road."

A STUDY OF ALBUMINURIA AND UREA.

EDWIN H. WOLCOTT, M.D., ROCHESTER, N. Y.

THE following cases are taken from the records of the maternity ward connected with the Rochester Homœopathic Hospital:

CASE I.—Mrs. H.; age 20 years; primipara. One urinary examination was made eight days before the confinement. Urine had specific gravity 1024 and no albumin. The day following labor thirty-one ounces of non-albuminous urine, specific gravity 1017, were drawn by catheter, and the next day thirty-five ounces of urine were taken by the same method. At 6 A.M. the following morning the patient was taken with convulsions, which recurred at frequent intervals until 3.30 P.M., when she died. Urine drawn at 7 and 10 A.M. showed albumin for the first time, which was present in decided amount. There were no casts found, and the only uræmic symptom before this time was a decided irritability of the stomach beginning immediately after the labor.

For the purposes of this paper it may be assumed that this was a case of functional albuminuria, and it is reported to place on record another case in my experience of the singular condition of albumin occurring in the urine as the direct result of eclampsia, and not its frequent cause, as is supposed.

On page 792 of Cazeaux and Tarnier's *Obstetrics*, we find this significant statement:

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"The amount of albumin in the urine increases greatly during the convulsive attack, and generally diminishes after it. This peculiarity has led some persons to inquire whether the eclampsia, instead of being due to the alteration of the urine, might not be the cause of it. I can understand why there might be hesitation in regard to this point, if a single case could be cited in which it had been proved that the urine was entirely free from albumin for several weeks before the appearance of the accidents; this, I believe, has never been done, but often, on the other hand, albuminuria has been known to be present for some time before the convulsions occurred. Besides, when we come to reflect upon the obstruction to the venous circulation produced by eclampsia, we can very readily account for the active congestion with which the internal organs, and the kidneys in particular, may be affected during the attack. Now, it is well known that renal congestion increases the secretion of albumin."

It cannot be stated that albumin did not exist in the case reported "for several weeks before the accident," but we do know that it did not exist for some time before the convulsions occurred.

The urine, you will remember, was examined eight days before and one day after confinement, without manifesting the presence of albumin. Naturally we have the right to expect that when pressure is made by the gravid uterus upon the renal vein or vena cava inferior sufficient to retard the returning circulation in the kidney and cause albumin, the albumin would have appeared sooner than one day after labor, and its occurrence, therefore, must be assigned to some other cause. Neither, in our opinion, does the theory of super-albuminosis obtain, for the reason that the woman was poorly nourished when she entered the hospital, and there was no artificial feeding of exclusively albuminous matters while she was under our care, to produce a temporary surplus of albumin in the blood sufficient to cause albuminuria.

How, then, are we to account for this condition? Largely, I think, as suggested by the author quoted, on the theory of general congestion of all internal organs, and especially congestion of the kidney produced by eclampsia.

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When the muscles are in a state of active contraction, the venous blood coming from the muscular tissues is very dark-colored. We also know that the muscular system forms a very large part of the entire mass of the body, and is intensely active during a convulsion. Naturally, then, this activity has a great influence upon the color of the venous blood in general. This color, judging from the change produced by the passage of the blood through the lungs, is largely due to the presence of carbonic acid. But highly colored venous blood contains something besides an abnormal amount of carbonic acid. It is surcharged with effete and poisonous materials caused by unusual waste, or an excessive physiological disintegration of the body. The blood, now having traversed the lungs, becomes arterial in name only. To accomplish its further purification it must come in contact with the capillary circulation of the kidney, whose function it is to eliminate these *excrementitious substances.* When these are excessive, an abnormal condition of engorgement takes place in the kidney, which is an important factor in renal congestion, and a consequent secretion of albumin.

The obstruction to the venous circulation from a general internal congestion, produced by eclampsia, is easily accounted for and need not detain us.

CASE II.—C. S.; age, 23 years; primipara; entered the hospital at 4.30 A.M., June 23, 1896, having had a convulsion, and was delivered by a high-forceps operation at 6 A.M. Sample of urine drawn at 3 A.M. contained a large amount of albumin, many granular casts and only $\frac{2}{10}$ per cent. of urea. During the day there were repeated convulsions and an increase in the amount of albumin. Sixteen ounces of urine were secured in fourteen hours. Urea varied from $\frac{2}{10}$ to $\frac{8}{10}$ per cent. Patient died at 8 P.M. Child was well nourished; is now alive and doing well.

CASE III.—Mrs. T.; age, 19 years; entered the hospital May 27, 1896, and was discharged July 29th. From the time she entered until her confinement a small amount of albumin was present. There were no casts, but a diminished amount of urea eliminated—two to three hundred grains daily. She was given careful preparatory treatment, as follows: Merc. corr. 3x, Buffalo Lithia Water, hot baths and milk diet. She was

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confined May 16th without the slightest complication, and the urine soon returned to normal.

All of the foregoing cases, when considered in the light of our present knowledge, indicate:

1st. That albumin in the urine has occurred as the direct result of eclampsia.

2d. When albumin occurs under conditions not eclamptic it is suggestive only, and does not in and of itself, unless especially abundant, cause any serious phenomena.

3d. That with albumin we generally find a diminished amount of urea eliminated.

4th. It is not admissible that urea alone is the toxic agent of urine, for large quantities are often retained in the blood or are injected therein without serious results.

5th. That according to Bouchard, there are at least seven toxic principles of the urine: *A diuretic* urea; a *narcotic*, unknown; a *sialogenous*, also unknown; a substance which contracts the pupil, and two convulsives, one unknown and the other an inorganic substance, potassium.

6th. "That the toxicity of urine cannot be explained by any one of these bodies singly. Each of them contributes a different share to the general toxicity—the coloring matter, $\frac{3}{10}$; the extractive matter, $\frac{1}{10}$ to $\frac{2}{10}$, and potass, and other mineral substances, $\frac{4}{10}$ to $\frac{5}{10}$."

7th. "In order that intoxication may be produced, it is not sufficient that the kidney should be diseased; it is necessary also that its permeability should be diminished to such a degree that it can no longer eliminate a sufficient amount of poison."

8th. Regarding the relation existing as cause and effect between the non-elimination of these poisonous substances and eclampsia, it would seem that a peculiarly sensitive condition of the nervous system must co-exist in the majority of cases to produce this disease.

It is our intention to pursue this interesting study in our hospital, and we hope to report more definite results at some future time.

DISCUSSION.

THEODORE J. GRAMM, M.D.: I, unfortunately, did not hear

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this paper. There is one point I wish to make, in reference to the general practitioner, and I always think of that point whenever I hear albuminuria mentioned. This point is in regard to the condition of eclampsia in conjunction with albuminuria. The fact is our obstetrical cases require that they should receive more careful examination than given by the general practitioner before the symptoms of eclampsia present themselves. By making an examination of the urine beforehand we place ourselves in a better condition to arrest trouble at its first appearance. The same is true in regard to the examination of the condition of women before bearing children. In every instance we should determine the condition of the pelvis and the relations of the fetus to the maternal parts. The examination of women prior to labor, both in regard to the pelvis and the condition of the urine, is of great importance.

JOSEPH C. GUERNSEY, M.D.: I recall to mind the case of a woman, three months pregnant. I made daily examinations of the urine and found it so full of albumin that it greatly exceeded the capacity of the measure, which was "Esbach's Albumenometer," seven grammes to the litre of urine. She had no very bad symptoms, a little backache, perhaps; but she was very self-willed; would go to the theatre at night, notwithstanding my admonition to remain indoors. I felt I was in for some trouble, and when I was sent for one night to see her, in the seventh month of her pregnancy, an examination revealed the head presenting. The child came away, a black, rotten, fetid mass, as well as the placental attachments; and it was then, for the first time in my experience, that I felt called upon to use douches of the bichloride of mercury. She passed through the lying-in period without fever or bad results; she made a good recovery; but the albumin held on for some time after the birth of the child, and finally disappeared. Microscopical examination showed large and coarse granular casts and some few hyaline. I wish to mention that this was as ugly and threatening a case as I would care to handle, but it turned out very happily.

WILLIAM W. VAN BAUN, M.D.: The paper read to us by our distinguished *confrère*, Dr. Wolcott, presents from the clinical

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standpoint some peculiar features. The urine of a young primipara just before labor showed a specific gravity of 1024, with no albumin. The day following her labor, specific gravity 1017, and still no albumin, but with convulsions, and death ten hours later, albumin only appearing four hours before the fatal termination, and some considerable time after the onset of convulsions. There were no tube casts, and there were no uræmic symptoms excepting an irritable stomach, beginning immediately after the labor. While it cannot be stated positively that this case presented no albuminuria some weeks before confinement, it is a fair inference that it did not, and the case goes far to establish the point that at times the albumin in the urine has occurred as the direct result of eclampsia, and that the eclampsia is not always due to the alteration in the urine.

ON THE IMPORTANCE OF MENTAL SYMPTOMS IN THE SELECTION OF THE REMEDY FOR THE SICK.

A. P. BOWIE, M.D., UNIONTOWN.

THE writings of Samuel Hahnemann do not include a work on the practice of medicine, with special therapeutics, for he understood well what has been said later by Grauvogel: "It is impossible to prepare a complete special therapia for any so-called disease; just as impossible as to describe all human beings of all times, because the conditions of getting sick change constantly in the course of time." But he did better; he gave us the *Organon* to be our clinical guide, and the *Materia Medica Pura* wherein we should seek our remedies. In disease the mind has special power over the body. The very word "disease" is coined to express a mental idea, "ease," and not a physical change. The cortex or surface of the brain—the seat of conscious mind—is a special factor for good or evil in every disease. Every organ and function is represented there, and there brought into vital unity. Prof. Laycock says: "The hemi-

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spheres as the organs of thought and mental action proper are in unity with all the processes of life whatever, whether they be termed vegetable or animal." Now with this thought I wish to call the attention of this Society to certain paragraphs of the *Organon* bearing on the subject of this paper. I now quote from our American master, Constantine Hering: "Every real follower of Hahnemann ought to know what he said in his *Organon*, from the first to the fifth editions, about the importance of the mind symptoms, and it is given here as an introduction, being translated by Dr. Conrad Wessellhœft." Let us hear our great master.

"Section 210: In all cases of disease we are called on to cure, the state of the patient's disposition is to be particularly noted, along with the totality of the symptoms, if we would trace an accurate picture of the disease, in order to be able therefrom to treat it homœopathically with success.

"Section 211: This holds good to such an extent that the disposition of the patient often chiefly determines the selection of the homœopathic remedy as being a decidedly characteristic symptom, which least of all remains concealed from the accurately-observing physician.

"Section 212: The creator of therapeutic agents has also had particular regard to this main feature of all diseases—the altered state of the disposition and the mind, for there is no powerful medicinal substance in the world which does not very notably alter the state of the disposition and mind in the healthy individual who tests it, and every medicine does so in a different manner.

"Section 213: We shall, therefore, never be able to cure conformably to nature—that is to say, homœopathically—if we do not in every case of disease, even such as are acute, observe along with the other symptoms those relating to the changes in the state of the mind and disposition, and if we do not select, for the patient's relief, from among the medicines a disease force which, in addition to the similarity of its other symptoms to those of the disease, is also capable of producing a similar state of the disposition and the mind." And in a foot-note to this section he adds: "Thus aconite will seldom or never effect either

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a rapid or permanent cure in a patient of a quiet, calm, equable disposition; and just as little will nux vomica be serviceable where the disposition is mild and phlegmatic, pulsatilla when it is happy, gay and obstinate, or ignatia where it is imperturbable and disposed to be neither frightened nor vexed." And following this we have his opinion in regard to so-called mental diseases, which is as true to-day as when first written, as I have not yet heard of the germs that cause acute mania or melancholia. And after such teachings as this why will we ignore these most important symptoms as contained in our materia medica? Is it because we know more than Hahnemann, or that we look upon such symptoms as trivial or unimportant? My own clinical experience teaches me otherwise, and well do I remember my first cures with chamomilla were dysmenorrhœa and croup where the mental symptoms led to the choice, and where the cures were prompt and permanent.

Dr. Gallavardin, in his work on *Alcoholism*, says we practise a species of veterinary homœopathy, meaning thereby we do not recognize the value and importance of looking at the mind and disposition of our patients.

And now, in the year 1896, this first centennial of the homœopathic healing art, Dr. Lauder Brunton says: "When boys become stupid, sulky and ill-tempered, some cane them; others, with a wider knowledge between mind and matter, give a dose of castor-oil, and not uncommonly with effects most salutary, for who is the boy who would not be sulky and ill-tempered in the prospect even of a dose of castor-oil?" Dr. Brunton applies the same principle to patients of greater age, and seeks by medicine to cure the irritability of temper which is commonly associated with gout and heart disease. Thus the first symptoms of our materia medica shall be the last for our old-school friends to adopt, and now surely the degenerate will be regenerated.

Bulwer, in *My Novel*, tells of a doctor who pulls out his case and administers a specific drug for every emotion or mental state—one for anger and one for grief, etc.

And some of our school wrote to him, and in a note at the end of the book he explains he intended no such thing, but had often consulted physicians of our school with advantage and

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relief. While I would not advocate such a use of our remedies, I think we could oftener get a clue to the proper remedy if we paid more attention to mental characteristics of our patients and their remedies. We hear a great deal nowadays about the healing power of faith, prayer, suggestion, and why not use this subtle power of our potencies when administering to a "mind diseased?" We know not the richness of our Materia Medica until we search its pages and let the importance of the mental symptoms be ever in our minds. And in this connection I would like to call the attention of the profession to Hering's *Analytical Therapeutics*, vol. I., "Mind Symptoms." One portion of that book—the part headed "Children"—is worth more than the price of the book. One remedy I wish to add to that list is assafœtida. Where children are afraid of the doctor or nurse, and will cry and howl when they approach them, especially when a sore needs to be dressed, not from the real pain, but in dread, and even where there is no sore, but where a joint is inflamed, it will relieve the sensitive condition if given in a high potency.

DISCUSSION.

JOHN C. MORGAN, M.D.: I am reminded by this paper of an article which I saw in a monthly magazine many years ago, which gave the name of the first homœopath who used aconite in pleurisy. This drug was given by a true Hahnemannian, without any reference to the inflammatory fever present, but only for the characteristic mental symptoms, such as anxiety, restlessness, etc. Notwithstanding that the fever interfered with these, aconite was given for the mental symptoms, and from that time aconite became an empirical remedy for fever, at first the almost ignored element of the malady.

CHARLES GILBERT, M.D.: I beg to say, in support of the paper just read in regard to the administration of large doses in mental diseases, that I consider the giving of such doses a waste of time. The higher the potency the more satisfactory will be the result.

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ON THE DANGER OF NEGLECTING BRONCHITES.

EDWARD R. SNADER, M.D., PHILADELPHIA.

Too many physicians habitually regard primary bronchitis as an affection of little moment, and think, inasmuch as the prognosis is favorable to recovery, that the inflammation of the bronchial mucous membrane requires but slight attention. The neglect of "colds on the chest," however, is not an insignificant error. We have all heard of those famed physicians who, according to the wise opinions of the laity, were "very good when a patient was very ill, but of little account in small ailments;" the sort of men, indeed, who reserve their therapeutic armamentarium until the wings of the Angel of Death flap weirdly in the faces of their patients and then tear therapeutics to tatters in their endeavors to save an unsavable sufferer, on whose brows the dews of death are already glistening. All this is very well. I believe in a physician reserving his forces; I believe in the healer who is heroic in the hour of horror; I believe in the masterful grasping of the disease situation and the striking of Cyclopean blows for life; I believe all this, and more—I believe in the prescient physician, whose mental make-up is of that exquisite equipoise that he sees the alpha and omega of his case, who needs no dramatic drivelling to excite his sympathies, no urging to do his full duty, who condescends to note small beginnings that may mean big endings. I admire the man who is ever and always the careful and conscientious physician, who is ever alert as to disease possibilities, and who is not electrically brilliant in spots.

Now, in a general sense, as regards life, leaving out of consideration the extremes of age, ordinary, every-day, so-called idiopathic bronchitis is not a grave disease. Many patients apparently promptly recover without any medication whatsoever. These are the peculiarly fortunate ones. Many other cases, however, do not yield speedily to either the efforts of nature or medicine. It is these stubborn cases that need care-

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ful watching, for there is always a sound reason in the human economy when nature apparently fails to make a cure.

The number of cases that make slow and incomplete recoveries are only known to those in the habit of making painstaking physical explorations of the thoracic organs. It is really surprising to note the persistence of râles, both moist and dry, long after the subsidence of the systemic symptoms and the more directly local phenomena of the bronchitis. The patient may declare himself well, and the cough, the expectoration, the substernal pain, may all have disappeared, and yet investigations disclose evidences of moisture and obstruction in the mucous membranes in the tubes. The subjective symptoms have fled, but the dregs of disease remain. The *symptoms* have folded their tents like the Arabs, and silently stolen away; but the evidences of their camp-fire remain as *signs* of their former habitation. In some instances I have observed those evidences of pre-existing, if not actually present, disease, six months or more after the subsidence of symptoms. I use the word "symptoms" here in contradistinction to the term "signs," as ordinarily employed by physical examiners. Now, the dry sounds I hear in these cases are not the fine-fiddling râles found in lungs that have been dry-docked, as it were, for want of use, for want of free expansion, for want of free aeration. These tiny creakings are plentiful enough in chests that are but seldom fully expanded. They may mean much; they may mean little. They are often pathological. Of the moist râles there can be no question. Moisture enough in the bronchial tubes or in the pulmonary parenchyma to give rise to bubbling is ever and always pathological; and the evidences of moisture continue for long periods of time after the so-called cure of the bronchitis. I have no doubt whatever that the dregs of bronchial inflammation persist for long, long periods of time. In the absence of systematic examinations to determine the time, save in only a few instances, I am not justified, I think, in insisting too strongly upon this point; but the limited number of cases in which I have noted the long persistence of physical signs is mightily suggestive of a similar state in a large percentage of cases. The reason for the lack of systematic observation on this

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point is sufficiently obvious, when you remember that few patients will be constantly under your care. With the disappearance of the annoying symptoms comes also the disappearance of the patient. One can only note the signs in such subjects as are continually under treatment for some ailment not connected with the bronchial apparatus, in whom the occurrence of an acute chest cold, as an intercurrent malady, offers you the opportunity of studying the after-effects of bronchitis. My observations have been made in just this class of cases, and are therefore fragmentary but suggestive.

Of the necessity of care in the complete cure of bronchial inflammations in the extremely young or the very aged you will all agree with me, I am sure. The reason is easily obvious. In the laxity of the muscular arrangement of the air-cells in young children, and in the rigidity of the same structures in the aged and atheromatous, there lurks actual danger, and possible nearby danger puts us upon the alert. But the foe is often hidden to those who make no chest explorations. In the weak alveolar resilience of the young, due to the slightly-developed muscular entrances into the vesicles, the draft of the inspired breath blows open the feeble-muscle-hinged doorway to the air cells, and may carry in and imprison therein the products of bronchial inflammation, and a broncho-pneumonia may there and then be inaugurated, for the power of expectoration is poor, and you readily conceive the difficulty a weak child will have in getting air enough beneath the infectious matter in the alveoli to raise it again to the larger bronchial tubes. Such a task is not a navy-yard job for a big, strong man. If it were not that Nature sometimes absorbs or otherwise disposes of the inhaled morbid materials, many cases of "cold on the chest" in infants in arms would of necessity end fatally. In the aged, a similar but different condition prevails—similar, in that in both there exists lack of ability to guard the entrances of the air-cells from the inhaled material taken up by the air-current in its passages through the bronchial tubes; different, in that in the young the muscular structure is weak from lack of development, and in the old is weak from atrophy of muscular structure, hardening of the connective tissue, and stiffening of the small tubes from the de-

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posit of calcareous salts. In the young the air-cells are easily opened, in the old they stand wide open. In the young the absorptives are active; in the aged, inactive. In both the danger is the same—catarrhal pneumonia. It is not hard to understand, then, why bronchitis in the young and old should receive most careful attention. This attention must continue after the subsidence of subjective symptoms; in fact, until all physical signs have disappeared.

It is less obvious, but nearly as important, that bronchitis should never be neglected at any age. No man is an absolutely well man. It would do my sympathetic, as well as cerebro-spinal system, a world of good to see such a man. If you ever see one, capture him by all means, and exhibit him in a medical museum. Man is only as healthy as his environments, his hereditary tendencies, his circumstances, permit. Health is only relative. We all have some underlying tendency to disease, some diathetic habit, some special predilection to ill health. We know, too, how often chronic bronchitis is a part and parcel of the symptomatology of certain classically-described disorders as half gout, full gout, lithæmia, rheumatism, anæmia, chlorosis, Bright's, syphilis, etc. We are aware, also, of the frequent presence of passive bronchial inflammation in valvular and mural heart affections, largely mechanical in origin. In any of the blood-ailments, certainly we can conceive of a poison-laden blood-current contaminating the vessel that attempts to purify it; the lungs cannot remove all impurities, and dregs are left behind to set up inflammation of the air-passages—more often the mucous membrane of the bronchial tubes, less often of the lung-structure proper. How many of these cases of secondary bronchitis, so-called, are actually predetermined by the existence of a latent bronchitis? Our gentlemen friends, who are busy with "bugs in bouillon," tell us that if they infect a rabbit's peritoneum with micro-organisms, and then wound the animal on the leg, or at some part distant from the site of infection, the minute growths will immediately appear at the wounded point. These microscopic growths seek the point of least resistance. Now, leaving out of the question altogether the discussion of disease-origin in micro-organisms, one thing appears reasonable. Dis-

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ease or abnormal tendencies seek the weakest part. So with latent bronchitis—that's a weak point. Diathetic taints manifest themselves more easily where an easy bed is made for them. Many of these blood-diseases do not have bronchitis in their clinical history, and in others the bronchitis is altogether disproportionate to the other phenomena; so much so as at times to conceal the real causal conditions from the ken of the unobservant. Is it possible that a special vulnerability of the bronchial mucous membrane prevails in these people? Yes, probably; but more probably, outside of exceptional cases, this special vulnerability of tissue was created by the retention of unresolved or partially resolved products of previous bronchial inflammation. This proposition seems fairly warrantable to my mind, for I have most carefully analyzed the histories of a large class of chronic bronchitic states, secondary to diathetic or underlying diseases; and I have many times found a history of frequent attacks of ordinary bronchitis, sometimes long prior to the development of symptoms pointing to the underlying systemic state, as the cause of the bronchitis. Both as a cause and complication, bronchitis may figure in this class of cases. You may say to me: "Oh, well, what's a chronic bronchitis? That's nothing. There's Mr. So-and-So—he's had it for fifteen years; and there's Grandmother Smith—hers must've come over in the Ark with her." All this looks pretty, one way; but that depends. I have known men to have syphilis for a long time; I have known patients to have valvular heart disease for many years, and I had knowledge of one individual who had gonorrhœa for fourteen years. (I trust I may remark, parenthetically, that he was not under my professional care). But, notwithstanding all these remarkable instances of resistance to disease, I do not think any of these affections, even the "innocent" chronic bronchitis, are desirable things to have. Few of us are built on such heroic lines as are Mr. So-and-So and dear Grandmother Smith. Besides, all experienced physicians know that a large proportion of chronic bronchitics are practically invalids, leading wretched lives.

An acute bronchitis is bad enough, but a chronic one is worse; and it is because so many of the acute ones really be-

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come latent chronic ones, that at any time may fulminate into a threatening inflammation, that I beg you not to neglect your colds on the chest because the primary symptoms have disappeared. You may consider this admonition a long-distance danger-signal—a sort of crossing the bridge before you come to it. That is true enough; but, individually, I always feel more comfortable when I know that possibly a bridge is to be crossed at some point in the health journey. I can at least turn up my therapeutic trousers and swell my medical biceps a few times in readiness to knock any impertinent toll-gate keeper into the river, without seriously compromising the serenity of my patient's trip healthward. Under such circumstances I am not troubled with anticipatory neurasthenia. But, seriously, when I treat disease, I must be aware of all its possibilities. Only with such knowledge can I do full justice to my patient and myself.

Aside from the possibility of an acute bronchitis becoming chronic in character, and of furnishing a soil for the development of a bronchial complication to general diseases and diathetic states, there is a danger, from neglecting bronchitis, in other quarters of the economy.

We know somewhat about the significance of small beginnings of disease that may ultimate seriously. We are constantly being taught by bitter experience that apparently trivial ailments—not alone through the continuity of structure, but also through the multiplicity of nerve conductivities and the destruction of the inter-dependence of normal functions, leading to the loss of the balance between the sympathetic and cerebro-spinal system—that little maladies—become paramount diseases—the tremendous nerve-waste of the sapping and mining of a disease-digger, who undermines the most colossal constitution ultimately by ceaseless rather than by herculean toil. Yet, with all we know, the mighty significance of little things regarding health is just dawning upon our comprehension. This paper of mine is but a contribution about a disease usually regarded as insignificant, and yet one which I believe the neglect of often leads to serious affections.

It seems to me more than reasonable, from my observations

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of groups of cases of consumption and bronchitis, that latent bronchial inflammation furnishes a suitable soil for the development of phthisis pulmonalis. The text-books tell you that what is called acute pulmonary tuberculosis often starts off without bronchitis, and occasionally you may meet with a case that is apparently typical in regard to this mode of origin. I say *apparently* with malice prepense, for I do not recall to mind now a single instance in which, in cases that did not present the symptoms of bronchitis, together with those indicating specifically a lung lesion, the physical signs did not reveal an abundance of moist râles, often more numerous, too, away from than at the seat of lung change. In other words, I found evidences of extensive bronchitis and evidences of very slight lung involvement. These râles could not be rationally assumed to indicate the existence of a so-called tubercular bronchitis, else, indeed, the symptoms of the lung disease would certainly have been more manifest and the physical signs more marked and general. The bronchitis was too much out of proportion to the spots of solidification.

Early, you know, the lesion in phthisis is generally one-sided, but the bronchitis of these incipient cases was bilateral and general. Now, while it is rare to have a case of phthisis begin with a great number of pulmonary symptoms and their systemic associates, and a paucity of bronchial symptoms, how almost universal it is for patients to describe their disease as originating in a "cold on the chest." The proportion of those who give histories of "colds" at the beginning is enormous as compared to those who start with distinctively pulmonary symptoms. It is a fairly reasonable assumption, then, that the vast majority of cases of phthisis pulmonalis have either latent or declared bronchitis before and at the very outset of their graver disease, rather than that the bronchitis begins with the lung lesion and develops *pari passu*.

It does not seem essential, in making this assumption, that it is at all necessary to take for granted the hypothesis that the pulmonary lesion must of necessity have its origin in a certain specific micro-organism and no other, and that the bronchial inflammation simply furnishes the soil. It is a mental moot-point with me whether a germ of a specific or any other kind

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is needed to *inaugurate* changes that are essentially and radically phthisical. An ulcer, or what is essentially an ulcer, can occur anywhere in the body, on your hand, your arm, your leg, and break down, and suppurate, provided only that there be lack of nutrition; and the causes that produce this lack of nutrition are numberless. Destructive tissue-changes are not, to my mind, of necessity dependent upon a single specific, only cause—micro-organic or not. Lack of nutrition in the lung, then, can lead to inflammation, to suppuration, to ulceration, to cavities, to cicatrization, and produce all the classical symptomatic evidences of an essential phthisis. You will certainly believe, with me, that all mucous membrane inflammations show lack of nutrition. Take a latent or pronounced bronchitis, with its products; carry these products into air-cells only half aerated, say by disease or enforced quietude from poor respiratory muscles,—what would be the probable effect of the presence of the foreign body (decomposing or decomposed mucus, blood corpuscles, etc.) but an irritation of the cell-walls, and, if the foreign body is not removed, inflammation and its consequences?

The anatomical difference in structure would make some difference in the symptoms and some difference in the pathological changes, but the whole process, if unchecked, would be, practically speaking, destructive, and certainly it is the destructive element that is the prominent feature in classical consumption. It apparently seems, then, that we do not need the tubercule bacilli to cause phthisis. An assumption quite near the truth would be that the majority of cases of consumption originate as broncho-pneumonias; whether the bacillus gets in and sets up a peculiar havoc afterward or not, is not essential to the question of causation. Whether the bronchitis furnishes the soil for the bacillus, or whether it favors the development of an initial catarrhal pneumonia which supplies a bed of roses for the germs, is not demonstrable positively, but the reasonable assumption seems to be that latent or declared bronchitis has a casual relationship to the development of tissue changes leading to pulmonary consolidation and destruction and the phenomena of the disease we denominate consumption of the lungs.

My growing belief in the importance of neglected bronchial

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inflammation as a possible pre-phthisical factor has, I think, sufficient grounds of justification to be presented you for serious consideration.

The relationship existing between asthma and bronchitis is pretty well understood by the majority of practitioners. The vicious circle established by the paroxysm of dyspnœa inducing bronchitis, and, *per contra*, the bronchitis re-inducing an attack of asthma, is fully appreciated, and, in the inter-paroxysmal periods of general bronchial spasm, therapeutic measures are adopted to remedy the bronchitis. All this is true of the class of cases frankly characterized by the obvious presence of bronchitis in the intervals between attacks; but it is not well known that many of the so-called purely neurotic asthmatics are sufferers from an undeclared bronchitis, *i.e.*, one presenting no symptoms, and recognizable only by physical signs. In these cases a very slight cold will induce what may be erroneously regarded as a typically neurotic paroxysm. I have found plenty of moist râles in a fair proportion of cases of nervous asthmatics, in whom no attack had been experienced for months, and yet the patients complained of neither cough nor expectoration. It is very plain, from all this, that the duty of attention to bronchitis in the inter-paroxysmal periods is of almost paramount importance, not only to prevent future attacks of asthma proper, but also to minimize the possibility of the asthma ultimately leading to a much more serious disease, vesicular emphysema.

These neglected bronchites, or perhaps I had better say symptomless bronchites, are sometimes only slight in extent, but are much more frequently quite general, and occupy not only the larger tubes, but also the medium-sized, and in some instances involve limited areas of the minute air-channels. I have not infrequently found spots of collapsed lung.

With these conditions confronting me, you cannot wonder that I insist that bronchitis shall not be considered cured because the symptoms have disappeared. Whenever it is possible I continue treatment until the physical signs of moisture and obstruction are no longer discoverable.

The bronchial inflammation is in itself a bad thing, by rea-

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son of its devitalizing effect upon the mucous membrane, its liability to lead to extreme shedding of epithelium, leaving the membrane bare and functionless and excreting fœtid products, to local ulceration, to suppuration, to submucus infiltration, to proliferation of connective tissue beneath the membrane and in the inter-bronchial tissue, to small sacculations (stagnant cavities poisoning the inspired air before it reaches the vesicles), to contortions of the tubes, to temporary collapse of limited areas of the pulmonary parenchyma, to sodden membranes, to local obstructions, to bronchial spasm. Now here's a "pretty mess" of possibilities from the neglect of a common every-day cold; but the half has not been told. The products of the inflammatory process act also mechanically, and by pressure on the arteries diminish the nutritive blood-supply, and by pressure on the veins induce localized venous congestions, and both these processes limit the amount of blood that can be oxygenated and put more work upon the heart. If a simple bronchitis induce a chronic one, all the trouble is augmented, and, the lungs becoming accustomed to handling only a limited amount of air, the respiratory muscles become lazy, and the chest expansion as well as the vital capacity become diminished. Thus the resistance to general disease of any description is lessened, and pulmonary disorders are, in particular, favored. The shifting collapse from the inhalation of the products of inflammation into the air-cells induces, by its frequent repetition, a lessening of resilience, muscular hypertrophy and atrophy, destroys the nervous balance of the parts, causes vaso-motor spasms and relaxations and pneumogastric irritability. Other conditions may arise also that a little thought will make comprehensible.

Because primary bronchitis is liable to become chronic, because, latent or otherwise, it favors the development of phthisis pulmonalis, increases the amount of bronchial inflammations in diathetic states and systemic diseases, because it favors the development of asthma, of emphysema, bronchial dilatation and contraction, and is liable to produce numberless other direct and indirect conditions, I believe bronchitis should never be considered as a trivial ailment.

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BROMINE IN DIPHTHERIA, CROUP AND DISEASES OF NERVE-CENTRES IN CHILDREN—CASES.

M. R. JAMISON, M.D., GREENSBURG.

THE only apology I have for reciting these cases of diphtheria is to increase, if possible, our faith in the efficacy of the homœopathic remedy in this dread disease, and to call attention how I think bromine should be administered.

At the present time much is being said and written in favor of the horse-serum in the treatment of diphtheria. Good authority gives it first place in the treatment of this disease, but equally good authority, on the other hand, regards it as useless, or even worse. Last winter the Board of Health of Chicago almost compelled citizens to use it, while the Faculty of the Chicago Homœopathic College believed it to cause death where life would otherwise have been saved. Personally I have had no experience with the horse-serum, but I do know, in the treatment of a large number of diphtheria cases, that the homœopathic remedy will cure a large percentage of cases.

In July, 1892, I was called to see a small child having valvular affection of the heart. After prescribing for this little patient, the mother called my attention to one of the boys, who, she said, had had a sore foot for a fortnight. The lad had not ceased to play, nor had he suffered pain until that day, but now his whole foot was hurting him. Between two toes I found a large, angry-looking fissure about a quarter of an inch in depth, covered with a membrane. There was no increase of temperature, neither was there any physical depression. The boy was apparently well, and as there was no diphtheria in the neighborhood, and not having seen diptheritic membrane occur upon the foot, or any part other than the throat, it did not occur to me that this was diphtheria, so I ordered it dusted with iodoform and the foot kept quiet. This soon relieved the pain, and in a few days the boy was all right. They informed me that their servant had been ailing with a similar sore on her

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foot. She continued to do her housework, though she did not feel well. However, the day before, the foot was hurting so much she gave up her work and went home to give the foot a rest.

One week afterward I was again called to this family, and found a girl aged five, and a boy aged nine, sick with diphtheria. Inspection revealed a yellowish-white membrane on the left tonsil, extending somewhat into the post-nares. There was a pricking sensation in the throat, much saliva and a very offensive breath, excessive prostration, and a temperature of 104°. The symptoms of both cases were the same, except that the boy had a slight hacking cough. Nitric acid, 2x, in water every hour was prescribed, with diet of milk and egg-nog. Both cases progressed fairly well for three days. Early in the afternoon of the fourth day the boy began to cough more frequently and was a little hoarser. I was not informed of these alarming symptoms until I made my usual visit at 7 P. M. Then I found the cough to be decidedly croupy, dyspnœa great, and the whole pharynx filled with the membrane, and evidently extending into the larynx. The boy was not able to lie down—had to be held upright, and breathing was quite difficult. A case of diphtheria of the larynx or diphtheritic croup was confronting me, and something must be done quickly or my patient would be an angel. I ordered hot pancakes to be placed on the larynx and changed every two minutes. I returned to my office and prepared a solution of bromine tincture, ten drops to an ounce of water. This I kept in a glass-corked vial, and gave one teaspoonful every twenty minutes. In a half-hour the breathing was easier, and in less than two hours he was coughing up large quantities of membrane. The hot pancakes were kept up till midnight, when he was able to lie down and breathe easy. Bromine was continued every hour, and finally every two hours the next day. He continued to cough up membrane for thirty-six hours, and finally made a good recovery. I am not sure it is necessary to prepare bromine in this way, but I am inclined to think it is. It is such a volatile drug that I have no confidence in it unless it is kept well corked, as I have given it. In this case I am inclined to believe that the quick results

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were due, in a measure, to the way in which the bromine was administered.

In the sister's case the membrane extended upward into the post-nares, and with careful nursing and the faithful administering of nitric acid and a nourishing diet she made a good recovery.

About one week after I had discharged my patients the child having the heart affection began to have a sore throat, and a diphtheritic patch appeared on the left tonsil. This was in the evening. The next morning the diphtheritic membrane had left the throat, and membrane had formed between two toes of the left foot and over the nail of the left thumb. The throat was perfectly clear and free from any membrane. The temperature was normal. The child was apparently well; no physical prostration; no elevation of temperature. When the foot was kept quiet and elevated there was no pain.

Evidently this was a case of diphtheria with the membrane upon the foot, as had been the first two cases in the family. For two weeks my patient sat in her little chair, holding her foot over her knee. For two weeks I applied local treatment of various sorts, with internal remedies on general principles, for I could find no remedy indicated. Finally the skin about the membrane took on a purplish hue, which led me to prescribe lach. 12x, when immediately improvement began. My patient was soon well, not only of diphtheria, but of the valvular regurgitation, the latter effected, no doubt, by the perfect quiet of three weeks.

GONORRHŒA IN THE MALE.

F. W. BURLINGAME, M.D., M'KEESPORT.

I NOTICE by the programme that I am expected to read an article on gonorrhœa. The title of this paper should more properly read, "What I Don't Know About Gonorrhœa and its Treatment," for after nearly fifteen years' practice, as well as three years' student's life, when I used to be consulted by un-

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fortunate acquaintances who had been indiscreet, I am ready to confess that any treatment for gonorrhœa that I am conversant with is liable to prove very unsatisfactory.

It was not my intention to inflict this Society with a paper of any kind this year, for, to adopt the phrase of the great Grover, I had fallen into "a state of innocuous desuetude," caused principally by the intolerable heat of the past summer and a natural tendency to avoid exertion.

I feel that I should be absolved and all blame should fall on the broad shoulders of our genial friend, Z. T. Miller, of Pittsburg, who, notwithstanding my avowed determination to hold my peace, with a persistency worthy a better result insisted that I send him the title of my paper.

At last, in sheer desperation, I wrote to him, explaining as best I could that I was only a poor, humble follower of Hahnemann; that my past year's experience had been uneventful; I had been plodding along, prescribing according to my light; that I was ashamed of my small death-list for the year, and so couldn't brag of that; that I never had a case of appendicitis to treat in my life, but that I had been bothered with some cases of gonorrhœa that persistently refused to dry up in spite of all my efforts. Now, what does Dr. Miller do but on the strength of that letter turn a joke into a tragedy and send in the title as printed in the programme.

Gonorrhœa, most commonly termed by the irresponsible laity clap, or "the disease that follows a circus," is a specific inflammation of the urethral tract. It is generally contracted by impure coition, unless the afflicted one be the head of a family, in which case it is usually contracted in a water-closet, notwithstanding the unfavorable surroundings.

And right here let me ask the duty of the physician in the latter case. The patient, a married man, comes to your office and confides in you. Anxiety is depicted in every line of his face, great beads of perspiration stand on his brow, and penitence fills his soul. There is something wrong that the poor fellow can't understand; he has a urethral discharge, and he can't imagine how he got it, or what it is; but, with all his innocence, there is a shivering dread when he thinks of home.

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You give him advice and treatment and dismiss him. Later, a little woman, with worried looks and fire flashing from her eyes, calls on you and demands of you to tell her what ails her husband. Is the physician justified in doing evil that good may come, *i.e.*, lie to the little woman, and thereby save a household from disruption? I say, yes. You can explain to her that her husband is suffering from urethritis (and that's no lie), a disease that all mankind is liable to be afflicted with; that it is a discharge similar to the leucorrhœal discharge in the female. It may be caused by a strain or cold, or by the depleted condition of the system, etc. And while you are explaining these truths to her, the Recording Angel steps out for a breath of fresh air, while the wife, full of pity, goes home and tenderly nurses the undeserving rascal.

The general cause of gonorrhœa is too well known to dwell upon at any great length at this time. We know that all persons are not equally susceptible to the disease.

After exposure, it usually takes from one to seven days to make its appearance, depending, to a great extent, upon the condition of the patient's system. If he has been carousing, he is more susceptible than the temperate man. Symptoms: First, he feels an uneasiness at the mouth of the urethra, and, if examined, the meatus will be a little flushed. Soon comes the burning and smarting while passing water. This increases until about the second day there will be a slight discharge of mucus of a yellowish color. We now get some pain just back of the glans while urinating. This is the first stage, or stage of incubation.

Now the symptoms become aggravated until we soon have pain along the whole urethral tract, and the discharge is thick, yellow, purulent and greenish.

The third stage, or stage of decline, sets in, according to some authorities, the second or third week; but I think it would be safer to say that it sets in sooner or later, sometimes considerably later, and has, I think, justly been named the stage of decline, from the fact that at times it seems to absolutely decline to heal up—that everlasting drop is there, and the patience of both physician and sufferer becomes well-nigh exhausted.

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As I before intimated, I make no pretence of being a specialist in this line; in fact I don't want the work; but every physician in general practice must be bothered with more or less of these cases, and if any suggestion can be made here of anything that will stop that "everlasting drop" quickly, and have it stay stopped, I will feel amply repaid for coming here.

I feel that I have had, on an average, excellent results in my treatment of the disease; still, in the past two years, I have had my patience terribly tried with three cases that seemed to defy all my efforts to cure. As a general thing I am well satisfied with the results of my treatment, although at times I am apt to adopt methods that would give a high-potency man a stroke of apoplexy, should he hear it.

Treatment of gonorrhœa should be conducted with a view of the general condition of the patient. Every man should be subjected to hygienic rules; teach him to observe strict rules of cleanliness.

Regulate his diet; allow him no highly-seasoned foods, fish, oysters, eggs, etc. Have him avoid all alcoholic drinks and fast women; avoid horse-back and bicycle riding.

It is better to put the patient to bed, but this is generally impossible. In the first stages of the disease no remedy acts as well as aconite, cantharis and cannabis sativa.

Aconite.—Acute inflammation, high fever, urine scanty and hot, and voided with great difficulty. Pain of a burning nature at neck of bladder at all times.

Cantharis.—Frequent desire to urinate, yet unable; great vesical tenesmus. Burning, cutting pains during micturation; discharge yellowish-green or bloody; spasmodic pains at neck of bladder. I usually give:

℞. Cantharis, 3d dil., ... f ʒiij
Aqua dist., q.s., ... f ℥iv M.
Sig.—Teaspoonful every two or three hours, according to severity.

Cannabis sat.—Burning and smarting the whole length of urethra during urination; penis sore and sensitive to touch; prepuce swollen and inflamed; discharge thin, watery, white or yellowish, sometimes greenish; frequent urging; prostate

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may be swollen; urine bloody. When prescribing can. sat. I use:

℞. Cannabis sat. θ . . . . . f ʒj
Aqua dist., q.s., ad . . . . . f ℥vj M.
Sig.—Teaspoonful every 3 hours.

I have found the cantharis and cannabis sat. to act well in alternation.

Mercurius.—Discharge worse at night; may be thin or greenish, thick and bloody; tenesmus; cutting pains; glans penis red and hot, with burning and stinging. To combat the acidity of the urine I usually give bicarbonate of soda, 10-grain doses, two or three times a day.

During the third stage I have generally used copaiva, cubebs or sandal-wood, and have had grand results with all three drugs used in conjunction. The sandal-wood oil is best given in 10-minim soft capsules; or, if you prefer the liquid form:

℞. Oil sandal-wood, ... f ʒjv
Syr. acaciæ, q.s., ad . . . . . f ℥iij
Oil gaultheriæ, ... gtts. x M.
Sig.—Teaspoonful before meals and at bed time.

The most successful formula for stubborn cases in my hands has been:

℞. Copaivæ, ... ʒx
Oil cubebs, ... f ʒj
Tinct. ferri chlor.,
Liq. potassæ, ... āā f ℥ij
Oil gaultheriæ, ... gtts. x
Syr. tolu, ... f ℥jv
Sig.—Teaspoonful three times a day.

The above prescription has a moral as well as a healing effect, for the patient is ready to swear that the remedy is worse than the disease, and is also ready to promise the Lord that if He will only help him out of this scrape he will never ask another favor of Him so long as he lives. In conjunction with the above prescription I often use the following injection with excellent results:

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℞. Zinc sulph., ... ℈j
Acid carbolic, ... grs. v
Vini opii,
Glycerini, ... āā f ℥ss
Aquæ camphor, ... f ℥v M.
Sig.—Inject after urinating.

The following is also good:

℞. Zinc sulph., ... grs. x
Fld. ex. hydrastis, ... f ℥ss
Aqua dest., q.s., ... f ℥jv M.
Sig.—Inject.

Listerine, peroxide of hydrogen, bichloride of mercury, 1 to 1000, nitrate of silver, 1 to 2000, are all good at times.

I had no intention of speaking of any of the complications of gonorrhœa when I commenced this article, but I cannot refrain from mentioning one of the most common, viz., chordee. "When the inflammation extends to the corpus spongiosum the erections become exceedingly painful, the frænum being drawn down while the body of the penis is forced upward," forming a curve. This state is called chordee, and I have been told that it is a condition that when once enjoyed will never be forgotten.

Do not forcibly extend the penis, for it is apt to rupture some of the blood-vessels and cause hæmorrhage and traumatic stricture. Always bend the penis in the direction of the concavity. The pain will be greatly relieved by bathing the penis freely in ice water. Camphor is one of the best remedies, and should be given in appreciable doses, five to eight drops of tincture every three or four hours. Monobromide of camphor is also an excellent remedy in 2 to 10-grain doses.

But I might as well close right here. If I should dwell on all the various complications it would only tend to increase your righteous indignation toward Dr. Miller, for personally, as I have before stated, I am not to be held responsible. I would add one fact, *i.e.*, in order to make a success in the treatment of any venereal trouble collect your fee in advance; that done, the patient will stick until cured or "until death do us part."

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DISCUSSION.

JOSEPH C. GUERNSEY, M.D.: I wish to say a few words in regard to the diagnosis of gonorrhœa, particularly in women. There is many a case of leucorrhœa that closely simulates gonorrhœa, and the only way to differentiate such cases is by a microscopic examination. There is no examination that gives more satisfaction than this. You simply take a drop of the suspected discharge and put it between two thin cover glasses; then you separate them, pour on your stain of methyl blue, wash off the excess of stain with running water and put it under the microscope. You can then see the gonococci, which will be found in groups of round bodies, resembling bunches of grapes, which have taken the stain. You are now positive of your diagnosis; you *know* it is a case of gonorrhœa. In your old cases of supposed improvement, when you are in doubt whether the patient is getting better or worse, by making an examination with the microscope once in a while you confirm your diagnosis. I remember the case of a young woman in this city who came to me to be treated for a miscarriage. The urine was heavily laden with albumin and she had a suspicious discharge. Not being satisfied whether it was gonorrhœa or leucorrhœa, I made a microscopic examination and endeavored to confirm my suspicions. The ocular examination of the vagina looked like gonorrhœa, and she presented all the symptoms of tenderness and pain on urinating, walking with her feet spread apart, and everything pointed to the disease. But I made the microscopic examination and found there was no sign of the gonococci of gonorrhœa. The method is so simple that all should make such microscopic examination, the same as they would in any suspected case of pulmonary tuberculosis.

I am old-fashioned in my ideas. I do not think that homœopathy is sufficiently lived up to, and I would like to have this Society go on record as declaring that there is no more deadly and dangerous method of practice than to treat gonorrhœa with any injections excepting pure warm water. The poison is driven back into the system, and goes down even to the third and fourth generation. Let us put ourselves on record as a Society as wholly and totally opposed to all injections in the treatment of gonorrhœa excepting pure water.

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THEODORE J. GRAMM, M.D.: I think, of all subjects that have come before the general practitioner, there is no one subject of so much importance in the treatment of both men and women as this subject of gonorrhœa. It has been estimated that from twenty-three to seventy per cent. of the diseases of women are due to the gonococcus. It is claimed that gonorrhœa in women is a simple matter; most of us have been taught this. The gonococcus gets into the vagina and does not seem to excite any serious difficulty there, and after some injections the disease appears to be materially improved. That is altogether untrue, and the best men of to-day have demonstrated it to be untrue. Gonorrhœa in the female varies. In some it will lurk in the vulvo-vaginal glands and cause abscess formations, after which the woman is apparently cured. There will be infection of the glands of Skene, whose ducts run parallel with the urethra in the female; and this can be easily demonstrated by passing the finger upward along the line of the urethra, and upon withdrawing it you will find it bathed in pus, filled with the micro-organisms of this disease. In addition you will find that this virus in the female causes endometritis, inflammation of the Fallopian tubes and ovaries, and this is the manner of formation of tubo-ovarian masses, so commonly found in women. Now, gentlemen, I ask you, is it not a serious matter for our consideration as men, physicians and homœopathists? Is it not necessary for us to consider this matter in all seriousness? What does it mean to have such an abscess formation? It means invalidism of a patient extending over years. Shall we speak lightly when one of a family is made an invalid by a disease like this? It is not an *indiscretion;* it is a crime. Gonorrhœa has been demonstrated to produce puerperal fever. How many physicians have found that blindness in children is brought about by this *indiscretion?* You will find, upon investigation, that gonorrhœa is more dangerous and widespread in its dire effects and a more fatal disease than syphilis.

Regarding the cure, it is claimed that gonorrhœa is never cured. I would like to say that if it be curable, it is only cured by the application of the principles of homœopathy. The old injections are being abandoned. This disease, especially the micro-organism causing it, is capable of demonstration by cul-

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ture methods, even when not demonstrable by the method spoken of by Dr. Guernsey. When you take the discharge from a case that is said to be cured, you can reproduce the gonococcus from the spores which the microscope does not reveal. Considering all the conditions, you will find that it is one of the most serious of modern diseases and is entitled to the fullest and deepest considerations of the medical profession.

ROBERT WALTER, M.D.: I have been anxious to hear some remarks upon hygiene with reference to this subject. I think the man who commits the indiscretion spoken of is entitled to live upon bread and water for two weeks to a month and to be shut up in a room where he cannot do himself or any one else any harm. He should be put upon a light diet, total abstinence, especially from beer and tobacco. I have never treated a case myself, but I have seen cases that were cured or supposed to be cured inside of two weeks by no other treatment than simple diet and sitz baths at a temperature of ninety degrees.

TWO CASES OF GONORRHŒA.

JOHN C. MORGAN, M.D., PHILADELPHIA.

THE two cases following were moderate, typical cases, but proved somewhat tedious. Only the latter part of the treatment is given in detail.

CASE I.—Mr. H. J. M., aged 34 years, a married man away from home, contracted gonorrhœa, with the usual symptoms. Latterly, and to-day, November 25, 1893,

Discharge, about eight drops per day, of pus; with

Burning while urinating;

Tired feeling below the knees, in the afternoon;

Return of an old pain, crampy, in the abdomen, coming from the hypochondriac regions, and extending to the hypogastrium gradually; lasting several hours at a time; better after eating; worse one hour or more after meals, with silent moving about

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of flatus; better by emission of the same; the pain, etc., ceases suddenly.

Habitually tired pain in the back, below the shoulders. Chilliness, daily, at noon, commencing in the same region. Prescribed, owing to a former experience of a like *colic* in the same patient, and cured by the same remedy, *dioscorea*, 2x, three times per day.

December 2.—"Feels good." Discharge has nearly ceased; only shows a wet appearance when pressing open the meatus. Burning very slight.

No abdominal pains during the week (except slightly yesterday and the day previous).

All other pains, also the chilliness, are entirely gone. Repeat same remedy twice a day.

December 9.—Reports "no pain all the intervening week until 5 P.M. to-day." Now has the abdominal pain as before, with upward drawing of the right testicle (the left always hangs low). He lifted a heavy weight at noon to-day. Has "felt first-rate all the week." The meatus urinarius is still wet within, and sometimes, in the morning, he can press a trivial amount, possibly a drop, of slightly opaque fluid therefrom, but not every day.

Same remedy, but having taken it this morning, repeat to-morrow morning, and afterward every second morning.

December 16.—No discharge during the past week, except once, several days ago, in the morning, he pressed out a little moisture, with a trivial show of opaque material. He gains constantly in flesh and strength. Feels very well. A slight urethral burning is still perceivable. No pains. ℞. *Sac. lac.*, once daily.

December 25.—No discharge or undue moisture in the urethra. No pains. Before and during micturition feels an agreeable tickling heat along the urethra.

January 6, 1894.—Only the slight sensation mentioned, and only in the middle of the glans, up to to-day; but this afternoon and evening pains again in the abdomen, from above downward, and to the left, in the course of the colon. (The left testicle is found to be the subject of a slight but old varico-

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cele. The pains really seem to begin therein, and go quickly upward; then, as above stated.) Relieved by passing flatus, *per anum.*

Prescribed a suspensory bandage, also, *dioscorea*, 500th, three doses, one hour apart, this evening, followed by *sac. lac.* Cured, as to the gonorrhœa; with improvement, as to the varicocele.

Case II.—Mr. W. F. B., aged 26 years, also a tedious case. In fact, I learned from it that a too conservative dosage, that is, as to repetition, is contraindicated in gonorrhœa, although high potencies are effective. He had been decidedly better, however, after *argentum nitricum* 200, followed by *silicea*, cm.; worse after *sulphur* 20, which had, previous to the first above named, however, done good. It now showed a yellowish, creamy discharge, and this got worse under *sac. lac.*, so that, on September 6, 1895, it is recorded: Pus slightly increased and thicker, and of deeper hue; slightly greenish, non-irritating, except forty-eight hours ago. ℞. *Pulsatilla* 200, four doses, six hours apart, followed by *sac. lac.*

September 11.—Discharge very slight. This morning, in urethra only, a fraction of a drop. About the same amount on the absorbent cotton at noon. (He uses this, with a "gonorrhœa bag," for protection of the clothing.)

September 24.—Little or no change. ℞. *Pulsatilla* 20, one dose.

September 29.—Ate gingerbread last evening; he thinks it has caused a slight (watery) increase of discharge; but it is still slight. ℞. *Sac. lac.*

October 3.—Very little of the watery discharge. The pus has fluctuated; now, as little as when at the best; almost all in the morning early. ℞. *Sac. lac.*

October 8.—Only as much pus as would equal a No. 30 pellet, lodged in meatus, in the morning. ℞. *Sac. lac.*

October 13.—Immediately after last visit increased discharge for two days; since, amelioration gradually; now about as before. ℞. *Sac. lac.*

October 18.—Worse. Discharge about one drop per day; stringy, firm. ℞. *Sulphur*, cm., one dose.

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October 24.—Discharge thinner, and increased in quantity, until yesterday, when it lessened; no more of the stringy material. ℞. *Sac. lac.*

October 29.—Daily, 3 drops of watery discharge; a little pus every morning. ℞. *Sac. lac.*

November 3.—No improvement. "Sore to touch underneath." Rather more of the watery discharge and the yellowish pus. ℞. *Mercurius vivus*, 200 (he is of swarthy complexion); five powders—one every night.

November 8.—Discharge improved, and less of it. ℞. Same, two more nightly doses, followed by *sac. lac.*

November 14.—Discharge better. ℞. *Sac. lac.*

November 19.—Less discharge. ℞. *Sac. lac.*

November 24.—The cotton is now only slightly dampened. Daily pus-discharge equal to two No. 45 pellets. ℞. *Sac. lac.*

December 5.—No pus; only a little moisture can now be squeezed out in the mornings. Nothing on the cotton. ℞. *Sac. lac.*

December 10.—Mainly unchanged. Only a little particle of viscid water can be pressed out in the morning; the lint adheres; almost nothing exudes at any other time; never any pus. ℞. *Mercurius vivus*, 200, three doses two hours apart, followed by *sac. lac.*

December 15.—Only a fraction of a drop of watery discharge in the morning; not at all viscid, almost entirely colorless; only emitted on strong pressure.

December 21.—Slight oozing, and transient sore spots within the prepuce. ℞. *Merc. viv.*, cm., three doses one hour apart; then *sac. lac.* Cleansing, as heretofore, frequently with hot water, including use of the same with syringe.

December 28.—Observes a small globule at a time of serum in the urethra, which includes a perceptible opaque particle scarcely to be emitted or pressed out. ℞. *Sulphur*, 200, four doses at intervals of two hours.

January 5, 1896.—He can scarcely press out anything; only a minute particle, and only in the morning. ℞. *Sac. lac.*

January 28.—A very small drop, on pressure, about noon,

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daily; transparent, but on opening the urethra there appears a little thread of opacity in the fluid. No abnormal sensations. ℞. *Lyc.*, cm., one dose, and *sac. lac.*

February 4.—Opacity in fluid almost gone. Total, but half of last time. ℞. *Sac. lac.*

February 11.—No discharge of any kind the last three days. ℞. *Sac. lac.*

February 24.—No discharge, or sensations, or any other symptoms, despite free diet. ℞. *Sac. lac.*

March 3.—No symptoms. Feels perfectly well. Discharged cured.

CASE III.—Mary P. B.; a fine-looking colored girl of 25 years of age; consulted me January 17, 1895. She had, until last summer, resided in Virginia. Her story was that a dissolute young colored man, in Virginia, last spring, had attempted a rape upon her; no doubt superstitiously expecting self-cure. His attempt resulted in a very slight lesion of the hymen, as revealed by ocular examination; but besides she had, after some days, and ever since, a steady yellowish, rather acrid, discharge from the vagina, with some burning on urinating. Prescribed *sepia* 200, night and morning; every second day three times. Also vaginal injections of hot water, two or three times a day.

[This same local measure, hot-water injections (per urethram), was used also, added to the drug treatment, in the male cases, but occasionally suspended.]

January 24.—Discharge and other symptoms are improved. ℞. *Sac. lac.*

January 31.—Better; continue treatment.

February 7.—Still better; continue.

February 14.—Unchanged. ℞. *Sepia* 200, three doses, one hour apart, this evening.

February 21.—Improving again. ℞. *Sac. lac.*

February 28.—Still improving. ℞. *Sac. lac.*

March 7.—Slightly better. ℞. *Sac. lac.*

March 14.—Unchanged. ℞. *Sepia* cm., two doses, night and morning.

March 21.—Better again. ℞. *Sac. lac.*

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March 28.—Improving. ℞. *Sac. lac.*
April 4.—Still improving. ℞. *Sac. lac.*
April 11.—Improving. ℞. *Sac. lac.*
Cured.—General health and strength, and spirits, much better also.

A CASE OF NEURITIS OF THE SCIATIC NERVE.

BY CHANDLER WEAVER, M.D., FOX CHASE, PHILADELPHIA.

JOHN S. S.; aged 34; fell from a load of hay, February, 1895, and was struck by the pole of hay-wagon somewhere over the left gluteal region, leaving no mark. In about a week he found that it hurt him to sit down, but had no trouble in walking or standing. In another week it began to pain him some at night and hurt more in walking and standing.

March 1st he put himself under the care of his family physician, going to his office at first, but soon becoming helpless in the left leg. By the second week in March he had to lie on a hard couch, flat; he could not even recline on pillows to read the daily papers.

The pain was crampy, sharp and tearing, and becoming worse at night, in the thigh especially, but some down the back of the leg. He could not bear any jarring or moving of the leg, and had to lie a little more on the right side, to take the weight of the leg from bearing on the couch, yet he could not lie on the side proper.

He was under constant allopathic care from March 1st until June 9th. The physician in charge called it sciatica, and had used counter-irritation in the way of lotions and leeches, and had a specialist, a professor on the nerves, from one of our colleges, in consultation, who suggested ether and forced flexion and extension, which was done; and finally, after that failing, offered the operation of cutting down on the nerve and stretching it, but was careful not to promise cure even with that.

He dismissed these physicians, and said he would try homœopathy before having the knife used.

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Now I find him on the 9th of June, 1895, certainly in a pitiful condition. A young man, in perfect health, except a painful and helpless left leg, fast on a hard couch, without having even pillows under his head, and with a wife and three children.

His pains were so great at times that he had to take an anodyne to get relief. His muscles softened and atrophied. He promised to follow my advice and do nothing else. I diagnosed a *neuritis*, and explained that to relieve a pain by an opiate would only increase the blood in the nerve and delay the cure. I encouraged absolute rest of that leg and used the hot-water bottle to painful points until I could get medicine to temper the pain down. I prescribed rhus 2x, in water. On my third daily visit I applied the faradic current over the region of the sciatic nerve, with the negative pole on the sole of the foot, and moved the positive down the nerve. I found six very sensitive points of inflammation, which he described, when I moved over them with the pole, as feeling like a sore boil.

I then took in consideration the cause of this whole trouble as being from a bruised nerve. As my pointed symptom I gave hypericum. The following day he said he really felt better, and improvement continued steadily under hyper. and battery applied every third or fourth day.

After finding that all the sore points had disappeared, I discontinued the hyper. and substituted rhus, on the 17th of July. Continued rhus until August 3d; then hypericum until September 7th, 1895.

By the middle of August he was able to walk about without any aggravation, but as the muscles were weak the walking had to be limited, increasing as the muscles hardened. Sitting in comfort was the last thing acquired, showing the cure was in the reverse order from the progress.

He was able to resume work on his farm the first week of September, and has been perfectly well since, not even having neuralgia following.

I report this case to show good reasons not to discard the cause which brings out a characteristic pointing to a recipe.

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The objective and subjective symptoms pointed as much, if not more, to rhus than hypericum, but the bruised nerve back of this pointed more to hypericum, which gave the most relief during the inflammatory condition, while later the rhus toned up the muscle after the nerve was ready to do its work. Do not forget your old, tried *characteristic*.

A CONSIDERATION OF THE EVILS OF PREVENTING FECUNDATION AND ABORTION PRODUCTION.

R. E. TOMLIN, M.D., PHILADELPHIA.

THE subject to which your thoughtful attention is invited may seem to be an indelicate one; if so, it is in the facts, and not in calling attention to them. The past winter and spring I was astonished to note the number of cases seeking advice as to the best method to prevent fecundation, or the quickest and most certain means of emptying the uterus should it take place.

It is the purpose of the writer to dwell particularly upon the apparent indifference so many people have in relation to the enormity of the offence, the possibility of incurring serious pelvic and constitutional disturbances, as the result of interference with normal physiological functions, and to briefly refer to some of the means adopted.

While most of these people were strangers to me, the nature of their visit, together with the number of cases, impressed my mind so forcibly that the conclusion was reached that if physicians, generally, were so importuned, the statement that the native American population is actually dying out would seem to be true. Herbert Spencer, in his "Sociology," pays a high tribute to American women and the way Americans bring up their children; but if what he says be true, "that preventive checks are the order of the day in America," then it must mean that we are not advancing on the lines of true civilization.

We are told that year by year the births from couples born

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in this country are less in proportion than those from couples one or both of whom are of foreign birth. The explanation of this startling fact has been traced by competent and conscientious physicians and political economists to the deliberate and widespread agreement, between those who are in the bonds of matrimony, that American women shall be childless, or nearly so.

The prevention of fecundation then becomes the chief object, and to secure this, numerous means have been devised. Failure to prevent fecundation very frequently leads to the practice of abortion.

Dr. H. N. Guernsey says: "It is wrong, frightfully wrong, to abuse or prevent the use of any of these physical organs, which are so sacred and so important to the welfare of the human family."

"Dishonor the body, the temple of the soul, and you dishonor the soul." No greater crime in the sight of Heaven exists to-day than that of preventing the natural use of marriage.

This is done in a great variety of ways, every one of which is criminal, in whatever form practiced, and none will escape the penalty. Nature's laws are inexorable; every transgression thereof is surely punished, even at the climacteric period, if not before. The question of failing health, or physical inability, or too frequent conceptions, are matters for the investigation, advice and decision of an experienced, judicious and upright physician.

Dr. Hanchett states, with regard to the avoidance and limitations of offspring, there is but one safe, sure and proper plan for the healthy, and that is to remain single, or, being married, to live as single. Any interference with the course of nature is a fraud that she will surely punish, and any attempt to rid the healthy body of the fruits of natural labor is certainly a cowardly crime, if it be not actual murder. No such attempts can be made without risking the life or health of the woman, and nothing can ever excuse them except the moral certainty that without them her life will be sacrificed.

Prof. William Goodell, after a long and honorable career, in the closing hours of his life informs us, in the last article he

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ever penned, that the most common cause of ill-health in women is the prevention of conception—a deplorable practice, which, like the plague of frogs, creeps into our "houses, bedchambers and beds." It comes from the dainty dilettanteism of our women, which shrinks from having its patrician pleasures and æsthetic tastes disturbed by the cares of matrimony. It comes from fashion, from selfishness, from pride, from indolent wealth and shiftless poverty. It comes from too high a standard of living, which creates many artificial wants, and demands many expensive luxuries.

I am amazed at the very low standard of morality, with regard to the sexual relations that obtains in the community. So low, indeed, has it fallen that I have known clergymen either themselves practicing preventive measures, or else abetting their wives in them, and physicians of repute teaching their patients how to avoid having offspring.

To these detestable practices do I attribute, in a great measure, much of the ill-health of our married women.

Why is it that the waiting-rooms of our gynæcologists are crowded with so many querulous and complaining women—women with groin-aches, backaches, headaches and spine-aches; women without sexual feeling, or else too weak to indulge in it? Why do so many women break down, either shortly after marriage or very soon after the birth of their first child?

It is, I answer, because the majority of them, false to their moral and physical obligations, are trying either not to have children or to limit their number.

It is because, by an immutable law of nature, there appears to be no harmless way by which "the seed of another life" can be made unfruitful.

It is because the wife, sinning the most, and most sinned against, suffers the most. Be the mode of prevention what it may, so much engorgement, and hyperplasia, and disorganization of the uterine structures and appendages are apt to take place in the women who keep themselves sterile, that their health breaks down, and they are liable to lose all sexual desire. Then, when they advance in age, and there comes that inevita-

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ble yearning and need for offspring, they find to their dismay that they cannot conceive, and they repeat the despairing cry of Rachel.

What physician is there of ripe years who has not been importuned by women hitherto wilfully barren, but now longing for children, to undo the mischief caused by such practices. He further says, "Criminal abortion is, alas! another too frequent cause of impaired health."

Being performed without antiseptic precautions, generally by illiterate persons of either sex, sometimes by the woman upon herself, or by the unskilled hand of a sympathizing neighbor, it slays its thousands. Of those who fortunately escape with their lives, many do so after an attack of peritonitis, which is liable to entail on them the lasting lesions of this disease.

Even should peritonitis not occur, endometritis usually will, or involution is arrested, and the enlarged and heavy womb is liable to displacement.

Time was when every prolific Roman matron received a civic reward; then she would exhibit her children as Cornelia did her twelve, and proudly say, "These be my jewels."

Dr. E. M. Hale informs us that the most common of all the initial causes of sterility are the various methods adopted by men and women to prevent conception. And he has seen cases of severe uterine colic, serious acute congestions, and even inflammation of the uterus and its adnexa, as well as cases of chronic endometritis with metrorrhagia, and incurable areolar hyperplasia result from the use of such methods.

While commenting upon the frequency of abortion-production in modern times, Dr. H. R. Storer states that in a very large proportion of cases this shocking and atrocious act is advised and abetted, if not compelled, by the husband. For the woman, enfeebled, perhaps, by too excessive child-bearing, for which her husband is generally wholly responsible, for few of our women do not become, sooner or later, virtually apathetic; for the woman, timid, easily alarmed, prone to mental depression, and dreading the yet safe and preferable labor that awaits her, there is a certain measure of excuse; for her husband, none, as it is he who induces her to visit the polite aborter, and to

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destroy the fruit of her womb, and thus imperil her own life and health.

A word here in reference to passion in women may be of interest. Dr. George Napheys declares the prevailing opinion that women are creatures of like passion with ourselves is erroneous; and that it is utterly untrue that they experience desires as ardent and often ungovernable as those which lead to so much evil in our own sex.

Mr. William Acton, M.R.C.S., well remarks that the love of home, of children, and of domestic duties are the only real passions they feel; and but for the desire to please their husbands and the natural desire of maternity would far rather be relieved from his attentions.

We may here briefly allude to any seeming justification for these procedures. Some observers tell us that the struggle for existence is so keen as to interfere with provision for the inhabitants of their countries. "Large families," they say, "are injurious to a nation; diminish the number, and there will be room for all." If we admit such a doctrine, why not resort to more thorough measures, and remove all who do not contribute to their own maintenance, such as the old, the insane, the incurably sick, the blind and the deformed? We would thus clear the ground effectually. Would society tolerate such a proposal? Its absurdity and injustice is at once apparent.

It is a strange justification many women offer in that they feel they were intended for better things than child-bearing, and that children hinder them from taking part in society, and prevent them from elevating themselves.

Is it true that woman is willing to be simply a plaything, to minister to man's licentious passions, or seek to fulfil the duties of social or business life, rather than to accept what has been in almost every age "the crowning glory of woman," that of "motherhood?"

Woman cannot change her nature as easily as she can her clothing. Celibacy is open to her if she has an objection to children.

Without woman's help we cannot cheek this deception, and unless we can awaken the conscience of women and make them

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feel that these acts are sinful, and that each act is a fraud, we shall not put an end to this evil. It is only by a contrast of results that we can save the most conscientious mothers from the fate which destroys maternal affection and the best children society can produce. How many mothers really give birth to children because they would not prevent it if they could?

What factor has more influence in causing the reduction of the number of children in so many families than the increasing crime of infanticide, direct or indirect?

We may not avoid the inevitable, yet we can influence many mothers to keep free from this grave offence, and be happier with a large family when age needs the protection of filial affection, and that love which makes memory all that humanity could desire; and the "brains, bone and sinew" of the American patriot, instead of dwindling rapidly towards extinction will become the inspiration and realization of his country for generations to come. It would be well if we could instil into the hearts and minds of all who are taking upon themselves the responsibilities of the marriage relation the noble words of that wise and good man, Dr. Constantine Hering that, "From a child still-born we can hope nothing, but *a child born alive, however feeble, may become a man.*"

Dr. Thomas Dolan, F.R.C.S., England, in referring to the differentiation that has been made between the living and the inanimate fœtus, fixed by the number of days that have passed as to the period at which life is manifest, distinctly states that as soon as impregnation has taken place a being is in process of formation, and that being has rights which should be safely guarded. This is the only logical position that can be assumed, and any attempt to destroy the fecundated ovum, the embryo, or the fœtus, must be regarded as infanticide, or criminal abortion.

This question might be considered in a purely religious aspect, a side upon which I need say very little, as this is not a religious assembly. Even so I could not hope to convince any who deny teaching that rests on faith; those who believe require no arguments to confirm them in their acceptance of the judgment placed upon the sin incurred by the prevention of fecundation.

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Another of the evils to which this paper alludes, and which needs only to be mentioned to be condemned, is the flood of impure literature scattered abroad, openly teaching how fecundation may be prevented; and, worse still, means are provided in the shape of plain and medicated tampons, syringes, sheathings, etc., and the practice of retraction recommended.

Dr. A. J. C. Skene plainly remarks that neurasthenia is often induced as the result of the means used to prevent conception, and the accompanying wear and tear on the nervous system from anxiety, depression, and perhaps an ever-present sense of wrong-doing.

The injurious consequences in the male, arising from the practice of retraction, or, more plainly, onanism, either extra or intra vas, are attested to by many professional men whose testimony is unimpeachable. In a general way they may be divided into neurasthenic, vascular and pulmonary, the first variety predominating. Dr. Thomas Dolan, speaking from his professional experience of these cases, wherein this practice has been followed for a number of years, says that the method of retraction is the most injurious of all methods to the male, in that it interferes with the natural gratification, overtaxing the nervous system, because the dual action is not suspended, as there is always the fear that the means used may not be successful.

The injurious effects in the female from the various methods used are similar to those occurring in the male, plus the local affections which arise in the uterus and its appendages. Aside from the fact that these practices offend against the natural law of reason and are detrimental to the interests of society and resorted to only by calculation, *they are physiologically injurious.* The production of abortion has already been briefly alluded to, and the serious pelvic lesions and constitutional disabilities arising therefrom are too well known to you to need further consideration in this paper. As a profession I am convinced we discountenance in private the acts included under the title of this paper. But is this enough? There are occasions when to be silent is to connive, and I feel and believe the time has come when this honored Society of the great Keystone State

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should speak out in no uncertain tones and declare the faith in them regarding this appalling and growing evil.

Individuals cannot do much, but a united profession can. The oath which Hippocrates, the "Father of Medicine," enunciated as a moral law in a pagan age, and which reads, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel, nor will I conspire with a woman to destroy her unborn child," has probably been faithfully observed by the medical profession through the changing centuries, and we who live in an age dignified as the "Christian dispensation" ought more strictly to follow in act and word its every injunction.

The supreme scope of medicine is to assist the moralist and the economist; the supreme direct scope to secure the healthy fulfilment of physiological functions, while the immediate scopes are to prevent disease in particular, and to remedy disease already contracted. Our role as physicians would indeed be limited if it were simply confined to the cure of the sick. Let us aspire to something higher; aim to make people healthier, consequently happier, and, I trust, better. In the whole domain of State and clinical medicine no questions can be raised so important as those affecting the perpetuation of our species and their sexual health. They concern the individual, the family, society. They are the primal questions.

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A COMPARATIVE STUDY OF THE URINARY INDICATIONS OF CHIMAPHILA UMBELLATA AND FABIANA IMBRICATA.

ROLAND T. WHITE, M.D., ALLEGHENY.

In calling your attention to these neglected remedies, I am persuaded that they are deserving of much more regard and study than they receive, and that they will, *sine dubia*, amply repay the prescriber, who will accurately discover their clinical uses by the alleviation of suffering among those tedious urinary and bladder affections which try the temper of both physician and patient.

The Chimaphila or pipsissewa is a small, perennial, evergreen plant, of the order ericaceæ, growing in the United States and Canada, while fabiana or pichi is of the solanaceæ order, and only found in South America.

Chimaphila, classically, is a diuretic tonic and astringent, and was formerly held in high esteem as a remedy for scrofula, rheumatism and nephritic affections; often compared with apocynum and uva ursi.

Fabiana is also a diuretic and tonic; used in gravel, vesical catarrh and certain forms of gastric disturbances.

Chimaphila seems especially applicable to the vesical and urinary disorders of women. The symptoms are distinctive and pronounced, but having many in common with several of the polychrest remedies used in these affections, such as frequent urination and tenesmus vesicæ, with cutting, smarting and burning pain during micturition; pain in the back, described as a sore, heavy feeling in the lumbo-sacrum, with dull aching in the hypogastrium; periodical attacks of tenesmus vesicæ, accompanied with burning, and followed by aching through the perinæum; aggravation in damp weather, and after getting the feet wet.

The amount of urine in the twenty-four hours is usually normal, but may be increased in those severe cases which are

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accompanied with mental disturbances, headache and nervous erethism, causing thirst and febrile state.

Cases suffering from chronic cystitis, vesical catarrh and irritation of the urethra: the urine rather offensive, turbid, neutral or very slightly acid; pus cells, bladder epithelium and increased phosphates; distressing tenesmus and a sore burning at the meatus are relieved by the lower potencies of chimaphila, as are also many vague symptoms following these disorders, viz.:

Stinging and burning pain in vagina and labia; rheumatic aching, with weakness and malaise in the extremities; pricking, with dry skin, burning of feet, hot flashes, etc.; also useful in vesical irritations which persist after confinement.

Fabiana seems especially relevant to the dysuria and a variety of urinary difficulties accompanying post-gonorrhœal complications, in the male, although its usefulness in women possessing the necessary indications has been fully demonstrated.

The general symptoms may be compared with merc. cor., canth. and cannabis sat.; very frequent, painful micturition, with tenesmus vesicæ; constant sore, burning ache at the neck of the bladder (prostatic urethra) after urinating, with aching in the hypogastrium through to the perinæum; urine turbid, with pus and epithelium; albumin, and occasionally casts (hyaline); anxiety, lassitude; sometimes with fever and general muscular soreness. These latter symptoms are clinical, and are probably due, in these cases, to sepsis from local suppuration.

A few clinical illustrations may here be of advantage in emphasizing the considerable field of usefulness of the drugs:

Case I.—Mrs. C.; age 36; mother of five children. Labors have always been difficult; last one, a year ago, emphasizing the rule; was a forceps delivery, uneventful recovery; but, on beginning to go about, discovers dysuria, with pain and distress in the bladder, characterized by paroxysmal, frequent, painful micturition, with tenesmus vesicæ, pain extending through the hypogastric organs to the perinæum.

The distress became so severe as to seemingly, at times, affect her mind, producing a brooding melancholy. She was under

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the care of physicians a considerable portion of the year; also taking anything recommended by interested friends, with, occasionally, temporary relief. Examination revealed a catarrhal state of the urethra and bladder; the urethra was dilated; urine neutral, turbid, with considerable vesical epithelium and pus; increased phosphates, with oxalate of calcium crystals, etc. Chimaphila produced marked improvement in a few days, which continued to complete recovery on following with a few intercurrent remedies as indicated.

CASE II.—Mrs. H.; age 52. Strangury, following colds, and bowel troubles. Painful tenesmus, with hypogastric aching; attacks at intervals of two years.

CASE III.—Mrs. A.; age 32; no children. One miscarriage, since which time suffered, at intervals, from attacks of dysuria. Pain described as cutting and burning, and great straining, leaving a sore, aching sensation through perinæum, extending along vagina. Urine turbid, with pus and epithelium, etc. These two cases were relieved promptly and efficiently by chimaphila alone.

A few short extracts from notes upon fabiana will more fully express its clinical value:

CASE I.—Mr. X.; age 54. Suppuration of prostatic urethra, with the usual symptoms of tenesmus; aching and anxiety; aching through loins and back; urine, albuminous; pus, epithelium, with considerable oxalate of calcium.

CASE II.—Mr. B.; age 45. Pain in left side and back, with dull soreness through hypogastrium; painful dysuria; urine turbid, neutral, loaded with pus and epithelium. Both cases cleared up with fabiana.

CASE III.—Mr. C.; age 35. Post-gonorrhœal stricture at prostatic urethra. At first attack of specific urethritis caused severe prostatitis; the prostate very much swollen and painful; urine entirely retained for two weeks, having to be removed by catheter: cloudy, with pus and epithelium; anxiety, fever and sweat. After the acute state, fabiana cleared up the case, relieving the resulting tenesmus and suppuration permanently.

These remedies have much in common from a clinical standpoint, *i.e.*, both have a special affinity for the urinary organs,

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but differ as to nature and degree of the disturbance produced, so the technical application of each is distinctive.

Chimaphila, from observation and historic uses, is known to produce decided constitutional disturbance of an inflammatory character, affecting the skin and causing a smooth erythematous inflammation, followed by desquamation; urine very scanty, and may be suppressed.

Of the two, fabiana is the most decided diuretic in its primary action, and the actual tissue change of the urinary tract, especially the bladder, is more pronounced, having frequently cured suppuration and relieved a concentric hypertrophy of that organ.

Chimaphila meets those chronic catarrhal congestions following cystitis, and seems to be characterized by periods of aggravation and amelioration.

Both are to be remembered in acute prostatitis, with fever, pain, dysuria and anxiety. A verified symptom of chimaphila is the feeling of a ball in perinæum when sitting.

These remedies in the primary potencies will not disappoint.

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REPORT OF THE BUREAU OF MATERIA MEDICA.

Rational Hypotheses of Drug Dynamics, by Roland T. White, M.D.
Materia-Medica Building and the Selection of the Remedy, by C. S. Middleton, M.D.
Apis and Zinc, by Edward Cranch, M.D.
Comments on Provings by the Pharmacological Society of the Hahnemann Medical College, by C. Mohr, M.D., President.
The Materia Medica, by C. S. Schwenk, M.D.
Notes on Ferrocyanide of Potash, by William G. Dietz, M.D.
Remedies Proven for the Homœopathic Materia Medica Now in Use by the Old and New Schools of Medical Practice, by Bushrod W. James, M.D.

RATIONAL HYPOTHESES OF DRUG DYNAMICS.

ROLAND T. WHITE, M.D., ALLEGHENY.

EXPRESSION is but the reflection of thought, and in amplifying upon a subject which is so closely in touch with the thoughtful physician's every-day experience I have only followed the impulse of tentative deduction.

Having waited in vain for some one of facile pen to take up the question of drug dynamics, looking through my spectacles of cogitation, I am impelled to approach the subject (so difficult to the reasoning assimilation) with some misgiving, realizing its importance in its relation to the science of medicine, so frequently requiring apologies, as demonstrated through the variety of ingenious arguments and the multiplied explanations of its rationale, in this, the century year of Homœopathy, when we are stimulated and regaled by erudite and eloquent discourses upon its phenomenal successes and achievements, the law of similia receiving that thoughtful and respectful attention wrest from its opponents through the convincing observation of its worth.

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When Hahnemann's life-history is earnestly searched, studiously examined, and critically scrutinized; his persecutions and vicissitudes deplored, which the bitter jealousies of superstitious ignorance imposed; his intellectual versatility and unselfish devotion to truth and the welfare of humanity eulogized and the memory of his genius venerated, the hour would seem propitious for queries and reflections, remembering for our consolation Channing's aphorism: "The learning commonly gathered from books is of less worth than the truths we gain from experience and reflection."

The phenomena of drug dynamics was a theory (but has since become an accepted principle either through the light of experience or by virtue of tolerance) promulgated first by Hahnemann as the only scientific rational explanation of the action and curative properties of drugs upon the human organism.

The *Organon* reads, Section 16: "Our vital force, that spirit-like dynamis, cannot be reached nor affected except by a spirit-like (dynamic) process, resulting from the hurtful influences of hostile agencies from the outer world acting upon the healthy organism and disturbing the harmonious process of life. Neither can the physician free the vital force from any of these morbid disturbances—*i.e.*, diseases—except likewise by spirit-like (dynamic, virtual) alterative powers of the appropriate remedies acting upon our spirit-like vital force, perceiving this remedial power through the omnipresent susceptibility of the nerves of the organism. Thus, healing remedies can and actually do restore health and vital harmony only by virtue of their dynamic action upon the vital force."

What a stumbling-block this seemingly vague hypothesis —drug dynamis—is to the uninitiated. It is accepted, believed and religiously defended by many of the followers of Hahnemann, although only passively tolerated by not an inconsiderable number of practitioners, who accept the law of similars while ignoring Hahnemann's logical deduction of dynamis, considering it of questionable importance, and not necessarily a portion of their homœopathic creed, and if the not overcommon virtue—courage of conviction—was more frequently

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exercised we would oftener hear outspoken skepticism. The subject of potentization also represents an ever-recurring, irritating question. We grapple with it, analyzing to a seemingly rational conclusion, but finally accept the self-evident facts of experience as sufficient for our needs; but, like Hamlet's ghost, the question returns to mock at our complacency by calling into question our intelligence:

Why a potentized remedy applied to some grave systemic disturbance will restore to a normal or state of health, even when this same substance is daily taken in considerable quantities and in crude form, or why it should be given in such intangible amounts as to paralyze the flights of fancy of even the most imaginative in following its attenuations, the brain incapable of travelling to that vast horizon of ethereal probabilities, eliminated by the magic of trituration and succussion?

Is there a limitation to this divisibility and attenuation of material elements? or can we be simply dealing with an abstract metaphysical question, as boundless as space, as unlimited as the ether encompassing the universe of revolving stars, as impalpable to our intelligence as the substance of light or the electric current travelling through the resisting density of its metal conductor?

Why should examples of the exceeding divisibility of matter, *e.g.*, musk giving forth in substance its odor for years without appreciable diminution in weight, be used as illustrations to emphasize the possibilities of infinitesimals? Does the drug-power lie simply in minute subdivision, and is it rational to infer that the healing-power of remedies increase as the quantity of substance becomes attenuated?

Tyndall demonstrated by light-refraction the existence of micro-organisms so minute that they were beyond definition of even the most powerful microscope.

Tesla, in a recent article in the *Electrical Review*, claims to have proven the material substance of the X-rays, which are capable of passing through solid bodies, illustrating the fanciful degree of divisibility of matter.

Shall we draw the inference from these experiments that the action of drugs in divisible form is due simply to minute sub-

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division? Dynamics, or the science which treats of the action of force, forms the foundation of every branch of natural philosophy, and reflective consciousness, analytical dissection of the amorphous facts of experience, represents the sum total of human knowledge.

Man unquestionably acknowledges dynamis, or the vital force (life), which animates every molecule, cell and fibre of his body through the conscious fact of identity.

Existence appeals as an ever-omnipresent fact to his consciousness. So the evolution of nebulous matter into a body animated by an evoluted nebulous soul is the natural deduction *a priori* of psychology.

This naturally leads to the hypothesis that disturbances of the vital force are primarily the cause of the material morbid bodily disturbances (disease).

Now, disease being primarily-disturbed dynamis—vital force—lowering the physical reactionary powers, it must, then, necessarily become susceptible, and succumbs to the changes which result in ferments, micro-organisms and retrograde metamorphoses; *i.e.*, disturbed dynamis means a specific sensibility to extraneous influences or predisposition.

Admitting this supposition, and looking to the laws governing physics and dynamics for proofs, we fail to find a single isolated force in nature, but each is accompanied by an equal and opposite compensating one. Thus it would seem impossible to rationally satisfy the demands of human reason by attributing the curative action of drugs in disturbances of the vital force by other hypotheses than their dynamic action.

The old-saw arguments satirizing homœopathy, compiled by Dr. Holmes in his essay upon attenuations, taking the mathematical speculations of infinitesimals to the limitation of our faculties, are overwhelmingly and conclusively unanswerable with their material reasoning; but, the dynamis of drugs proven, such arguments at once vanish, dissipated by a higher law, a nobler creation.

The arrows of ridicule and sophistry, whose sharp points reek with the venom of our nineteenth-century materialism, fall harmless with their pitiful over-self-confidence.

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Geometrical precision in dealing with the physical manifestations of disturbed vital force (disease) in man (a dual complex personality, an aggregation of cells, the delicate pose of equilibrium between the material animal and immaterial spirit, associated in harmony with an intensely-strung, vibrating, nervous organization, creating a primal unity of action between soul and body) would seem, for obvious reasons, impossible to obtain.

Even provings carried out upon animals (with the intent of producing drug-disease and curing such disorders by drugs) will only give verification in crude generalities; such provings must be verified and crystallized by careful observation of their action upon man.

From the miracles of early times through all the labyrinthian windings of medical dogmas, creeds and faiths, from the Yoga occultism to hypnotism and modern scientific medicine, the application of the law of dynamics, form the underlying fundamental principle of cure, *i.e.*, faith or suggestion—through the vital force acting upon the material body—producing a positive reaction against the negative morbific disturbing dynamis (disease).

Again, even the earliest aborigines probably accomplished their crude cures instinctively, according to the law of similia, by selecting their simple remedies for the cure of their sick from the herbs of the fields through some unaccountable spontaneous intelligence of their value; and we may still study instinctive medication among portions of the animal kingdom.

Archæological study and investigation in ethnology constantly demonstrate the truth of the maxim, "Nothing new under the sun." The electric light and the telephone, old as the sphinx; the printing-press, and even the stereotype-plate, gave to the ancients the daily news. So may not some former people have possessed knowledge of the truth of similia and dynamics, wrested from the realm of synthetic reasoning? Investigation and argument can only reinforce the hypothesis of drug dynamis, and that it is as necessarily, *per se*, a portion of homœopathy as the law of similia.

But that this drug-force must be associated with the ultimate

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material elements of divisibility is a question still debatable. Certainly there must be a limit to potential attenuation, and the craze for fanciful extremes of dilutions seems not only illogical, but a presumptuous abuse, misleading and bewildering; aborting earnest effort in the logical development of the resources and possibilities of homœopathy.

To affirm the proposition herein elaborated without further arguments, pro and con, we can only emphasize the conclusions reached by Hahnemann a century ago:

1st. Drugs have the power of disturbing the harmony of the vital force, manifested by the deranged equilibrium of the physical unity.

2d. Drugs exert their curative powers upon morbid disturbances (disease) by the released potential energy (dynamis) set free through the process of succussion and trituration.

The question of dynamis must appeal to the least imaginative as a grand conception of the relation and principle of drug and disease, a comforting truth to our intelligence, perhaps a spark of the iridescent radiance of the Divine favor, approaching the immortal in man.

All honor to Hahnemann, whose gifted perceptions and unshrinking courage made possible the development and dissemination of this life-giving truth.

DISCUSSION.

CHARLES B. GILBERT, M.D.: Referring to the provings of Hering, I remember a story concerning Dr. Jeanes. He was given a dose of some drug, the name of which I have forgotten; and immediately afterwards, when the symptoms began to develop, he paced up and down the floor furiously, seized his wig and threw it on the floor, evidently relieving the great pressure that the drug produced in the head. He had the appearance as though he was going to die, but Dr. Hering said he scribbled on while Dr. Jeanes did his talking; and finally Mrs. Jeanes came in and administered some strong coffee to him, and stopped his symptoms.

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MATERIA-MEDICA BUILDING AND THE SELECTION OF THE REMEDY.

C. S. MIDDLETON, M.D., PHILADELPHIA.

THIS subject is one of such magnitude that it is with the keenest sense of temerity that the writer attempts to express his opinions upon this important branch of medicine. It is, however, because of this importance that the writer, rather than present some compilation in lieu of original work, concluded, at the earnest solicitation of the Chairman of the Bureau, to give him something in different form.

In the first place, what are we to understand by Materia-Medica building?

Certainly not the mere piling up of such enormous stacks of symptoms as seems to be in vogue during the past few years.

The first materia-medica building, of course, is that brought down to us by the old school, and may be likened to the rough stones required for the foundation of a substantial superstructure—it can be of use to the homœopath only in giving him a groundwork upon which to erect, if not the most beautiful, the most useful of materia-medica structures.

The first materia-medica building for the use of the homœopathist was that of the *Materia Medica Pura*, by Hahnemann.

Hahnemann already had the benefit of his knowledge of all the works of the old school, and it therefore explains the scheme arranged by him for our use; it is a natural and logical result following the classification of the materia medica of that day.

His knowledge of the action of drugs in large doses, and his disappointing experience with large doses under his newly-applied system, naturally led him to expect manifestations of drug-action upon the same organs and tissues in smaller doses by systematic proving; hence the greater number of symptoms elicited by that means.

The disposition now, however, seems to be to lose sight of

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everything but symptom-building, which is getting to be something formidable.

There have been some strong protests against such enormous expansions of our symptomatology, and efforts have been made to keep the literature on the subject within reasonable limit.

It is one thing to protest and another thing to offer an acceptable remedy.

What, then, shall we do to produce a materia medica which shall be at the same time pure, sufficient, and limited to a practical degree?

This is the question, and it is one not easily answered. Many have tried, and most, if not all, have failed; one, because he has condensed too much; another, because he has not been sufficiently brief, and has included symptoms not of any correlative value. Who is to decide the best course to pursue?

One great difficulty by which the materia medica has been so largely increased seems to be the desire to see how *many* symptoms can be recorded in a "proving;" and, with the utmost regard for the sincerity of the prover, there can be no question that many "symptoms" have been accepted which should never have been incorporated in the materia medica.

The fact that such danger existed was keenly appreciated by Hahnemann, as evidenced in his preface to the *Materia Medica Pura*, pages 6 and 7; but so nearly perfect, or, at least, so acceptable was his work, that those of us who had to rely upon the materia medica of forty years ago can testify that it was easier to select a remedy, and perhaps it could be done with greater precision, then than now.

In view of what the writer has already said, it is a logical sequence that the question should be put to him, "Well, what are you going to do about it?" And the answer would be, "I don't know, exactly." But would it not be well to begin all over again?

Let us begin where Hahnemann left off, to revise and reprove where necessary. I would go a step farther back of that, however; let us incorporate into one groundwork the history of each drug, description, etc., to which kingdom it may belong, its process of preparation, its physiological and poisonous

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effects, its action on the different organs and tissues, its affinity —(this of itself would be of great value for indicating its uses in the more acute diseases), its use by the old school, finishing the structure with the beautifying touches of undoubted symptoms elicited by thorough and verified provings, discarding everything that could not be corroborated, and that would not follow as a sequence, or be verified with the known and substantiated action of the drug on its affinitive tissues and organs from a rational standpoint.

Under such circumstances it would be necessary for us to adhere closely to our knowledge of pathology, and to make comparisons between the latter and drug-action.

It must be borne in mind that in this department there is almost entire uniformity of manifestation, but much variation as to degree of intensity of action.

These considerations lead us to associate certain remedies having affinitive action on certain parts of the body; this would be the first step towards materia-medica building and learning the drug-action and the disease-picture.

I am aware that such a course would be objectionable to many who consider symptoms of drugs coming from old-school sources as entirely unreliable. Hahnemann says the action of drugs in the dose large enough to produce what we call physiological or poisonous effects "is much less the genuine effect of those substances than an endeavor on the part of the organism to annihilate in the shortest possible period the specific effect of those medicinal substances."

But, even so, such action is uniform, and by such action we recognize the fact that these drugs *always* manifest their affinity for certain organs and tissues by the necessity of these same organs and tissues making the same efforts "to annihilate in the shortest possible period the *specific* effects of these medicinal substances."

While discarding the old-school materia medica as being of little value as a symptomatology, nevertheless Hahnemann devotes more than a page in enumerating the symptoms of a fatal case of poisoning with angustura, as well as in other instances. As before remarked, this process might be considered a ground-

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work only, which would require a broad knowledge of drug-action, pathology and physiology, but certainly should be regarded as a sign-board pointing the way to the selection of the remedy for the cure of many of the more acute forms of disease. But now comes the most important, and at the same time the most vexatious, part of our task—the proving of the drug, to secure all the finer shades and effects of the drug-picture, by which we may be aided in selecting the remedy as the various shades and modifications require, due to idiosyncrasies, temperament and bodily condition. The difficulty of securing entirely satisfactory provers is one that is almost insurmountable.

First, because so few people can be considered perfectly healthy.

Either they, the so-called healthy, have some slight functional ailment, or a certain degree of some chronic disease.

Provings from such persons were looked upon with suspicion during Hahnemann's time. He required that the person should be in "perfect health, and living in contentment and comparative ease."

"When an extraordinary circumstance of any kind—fright, chagrin, fear, external injuries, the excessive enjoyment of any one pleasure, or some great event—supervened during the trial, then no symptom has been recorded after such an event, *in order to prevent spurious symptoms being noted as genuine.*" But that such symptoms (unreliable) did creep in is manifest by the fact that they were placed "in brackets, for the purpose of informing the reader that they could not be considered decisively genuine."

This, then, is the outline for a materia medica which shall be something more than a symptomatology, replete with verbiage, possessing something tangible for the mind of the student to grasp, rather than to attempt to memorize a symptomatology of such magnitude.

A more comprehensive view of both the materia medica and of the disease-picture would thus be obtainable, leading to a more accurate selection of the remedy and a more satisfactory result.

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APIS AND ZINC.

BY EDWARD CRANCH, M.D., ERIE.

Apis and zinc have in many ways a certain relation to each other of acute and chronic, not inimical, as are the two more similar acute remedies, apis and rhus, but complementary, as are nux vomica and kali carbonicum.

Both apis and zinc give rise to symptoms of hydrocephalus, such as follow suppressed eruptions, with dulness, shrill screams and afternoon aggravation. Both have stinging pains, erythematous eruptions, conjunctivitis, stomatitis, nephritis, proctitis, suffocative cough, convulsions, and that rather peculiar symptom, fidgetty feet.

Mentally, both cause irritability, depression of spirits, anxiety, bewilderment and unconsciousness. More particularly the apis subject is much given to *whining*, and this whining voice was one of Dr. Lippe's especial key-notes for apis, and has many times been usefully verified. The apis patient, if a woman, is apt to be of a jealous temper, besides being clumsy, letting the dishes she is wiping, or the bric-a-brac she is dusting, fall to the floor. If very sick, she confidently predicts her death, which event the zinc patient views with entire equanimity, although very sensitive to noises and to the talk of others. Both sets of patients are of changeable, fickle temper and uncertain in their continuity of application.

Both apis and zinc will relieve headaches, acute and chronic. The chronic headaches of zinc have specially painful and tender spots, and are often seen in nervous prostration and in chlorosis, its acute headaches are mostly from worry or fatigue, and have the fidgetty feet as a marked accompaniment. The headaches of apis are violent, stormy, with fulness and burning, and with puffiness of the face, cold water relieves, heat is aggravating, especially near a stove. A comparison may be had with glonoine, with its still more violent throbbing; with belladonna, with its great thirst and desire to wrap up warmly, in spite of

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a partial relief from cold water, and with silicea, with its characteristic relief from hot applications, even from poultices. Apis and zinc both have falling of the hair.

Both apis and zinc have many eye-symptoms in common, as conjunctivitis, lachrymation, photophobia, and stinging pains, only apis has more œdema, always of a red color, often with the most serious inflammation, so that, as Hoyne reports it, "the whole eye looks alike." Both drugs have ulcers on the cornea, iritis and pannus. Zinc especially will cause and cure pterygium, sharing this distinction with rhatania. Zinc is useful in granular lids, and the presence of a green halo in the vision of the zinc patient may prove to be a valuable hint.

Apis alone is very useful in facial erysipelas, violent, but without thirst, while zinc is of especial value in the cachectic neuralgias that often follow such cases. Both drugs have stomatitis, with rows of aphthous ulcers anywhere in the mouth, or fauces, but apis has the acute form of a fast-swelling glossitis, with or without profuse salivation, and apis is also of the utmost value in diphtheria, when the acute symptoms peculiar to apis are present, œdema, thirstlessness, numbness of hands and feet, scanty urine, stinging pains, aggravation from heat of stove, and at three or four in the afternoon.

Both remedies have soreness of the whole alimentary canal, including the anus, but the stool of apis is very easily expelled, in spite of the pain in the bowels; in fact, in children, the anus may be seen standing open all the time. Both drugs have colic, and both are useful in the cephalic symptoms that often supervene upon cholera infantum, and are known by the name of hydrocephaloid. Zinc extends its action to the state of torpor of the intestines that follows or alternates with protracted diarrhœa.

Hoyne recommends apis in trichinosis; its peculiar pains and swelling make it homœopathic to this dreaded condition.

Both drugs have enlargement of liver with commencing dropsy, but apis has the more acute pain and soreness. The desires and aversions of zinc are more marked in particularity than in apis, which has general loss of appetite and of thirst, while under zinc the patient refuses sweets, fish, veal, milk and

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many warm dishes; he is always made worse by wine, yet what he does eat or drink he takes hastily, as if greedily. The zinc patient is generally thirsty.

In the urinary tract the effects of apis are more violent and acutely inflammatory than those of zinc; the former having acute nephritis with dropsy and albuminuria, while the latter is more often useful in gravel, as its characteristic symptoms will show. The secretion of urine under apis goes to extremes, very profuse or very scanty, and always with frequent urging. With zinc the pains, as in other situations, are more neuralgic than inflammatory.

In the female sexual sphere the action of either drug will cause leucorrhœa, uterine pains, menstrual clots, pruritus and nymphomania. Apis, however, has a stronger affinity for the ovary, causing ovaritis, oöphoralgia and ovarian dropsy.

Both drugs cause cough, hæmoptysis, and suffocation; under apis the sufferer feels as if he could not draw another breath; the feeling is analogous to that other interesting symptom of apis, "cannot strain at stool without feeling as if something would burst;" the cough of zinc is as if one would suffocate from the continuous fine tickling in the lungs. In the back and extremities there is stiffness under both drugs, but more lassitude and weariness under zinc, more numbness and swelling under apis.

Both drugs cause convulsions, general under apis, more localized under zinc, which also displays peculiar tremors.

The skin symptoms of apis and zinc are surprisingly similar, being both under the control of the nervous system, forming urticaria, itching and pimples, all more acute and fiery under apis, more protracted and cachectic under zinc. Both cause heavy sleep, interrupted by dreams with starting or screaming. Both have much chilliness, with faintness and sweating, both have fever and delirium, both have marked aggravation at 3 P.M. Apis has the wider range of ailments, but zinc comes in in many of the same ailments, only more often when these have reached their chronic stage. Both are very positive remedies, and undoubted in their action when they do act, which is always, in almost any potency, when the symptoms agree.

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PROVINGS BY THE PHARMACOLOGICAL SOCIETY OF THE HAHNEMANN MEDICAL COLLEGE.

CHARLES MOHR, M.D., PRESIDENT.

Mr. President, Ladies and Gentlemen:

I hold in my hand a voluminous paper, a paper prepared by the efforts of many men. This paper, I trust, in the course of time will appear in the TRANSACTIONS, as it gives one of the most exhaustive provings of acetanilid that has ever been made, and in these provings we have taken nothing for granted. We have gone over the matter in a perfectly scientific manner, and have endeavored to present as true a pathogenesis of this drug as it is possible to produce, and as voluminous as this paper is, the proving is not yet complete. It may be well for me to say that the Pharmacological Society under whose auspices the provings have been conducted was organized one year ago. It has been managed by *specialists* in medicine, whose duty it is to see that no error creeps into the records of provings, and that nothing is put down as a fact which has not been thoroughly tested and which cannot be demonstrated over again. In arriving at this result we have been hard at work. I want to call your attention to just a few points to show how difficult it is to conduct a proving, and to give an idea of the methods produced by our Society. We had two hundred and seventy-five students in the class last session. Notwithstanding that appeals were made from the desk to the class and to individual students personally, out of that number we got only thirty-two men who would agree to undergo the drug experimentation; of these thirty-two only thirteen completed in every particular the requirements which it was necessary that each of them should meet before they were put under the influence of the drug, and these thirteen were the only men who took the drug after the preliminary examinations were completed. Three of these thirty-two very nearly met the

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preliminary requirements. Four came far from meeting them, and the other twelve failed to do anything except to give in their names as provers. So out of two hundred and seventy-five students we could get only thirteen men who were willing to undertake the ordeal which our Society desired to put them through. None of these students knew what the drug was; they could not know, for everything was so guarded and the preparations were given in such a way that the members of the class supposed that they were taking different drugs. Then, furthermore, each one of these gentlemen was in honor bound not to divulge or talk about any of the symptoms he experienced to anyone of the several members of the Society who had contracted to aid in the proving. This was done in order to guard the proving as much as possible from collusion, autohypnotism and the like, which have so frequently damaged the provings undertaken in a class. Each of these provers was instructed to follow the succeeding directions:

RULES FOR PROVERS.

1. Fill out the Prover's Preliminary Record on blank herewith furnished.

2. Present yourself to the examiners marked on this card as soon as possible, for special examination.

3. During the proving, live as ordinarily as to diet, exercise, sleep, etc., and avoid everything that may interfere with or vitiate the drug effects.

4. Use a separate sheet for the record of each day of the proving, and write on one side only. Note the condition or state of the weather each day.

5. Note the time of the taking of each dose and its size. As soon as any dose produces an effect, however slight, take no more of the drug, and note every disturbance of function, feeling or emotion. Every pain or abnormal sensation or appearance must be clearly defined as to character and exactly located. Note the precise time of the appearance and disappearance of every symptom, and under what circumstances the symptoms are made worse or better. In case any of the symptoms experienced and noted have previously occurred, when not under drug influence, mention the fact.

6. As often as is mutually convenient, present yourself to the director of your proving for inspection, and submit your daily record for such explanation of symptoms as may be necessary for a clearer understanding. Explanatory notes and corrections should be made on the margin of the record sheet, by the director of the proving only. The inspection should embrace every diagnostic test applicable, whether with the ophthalmoscope, laryngoscope, stethoscope, sphygmograph, or other instrument. The quantity of urine voided, the color of the urine, its reaction and its constituents, as demonstrated by chemical tests and the microscope, should be noted. Whenever directed to present yourself to an examiner, do so at the specified time.

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7. As soon as each proving is completed, forward the record to

CHARLES MOHR, M.D.,
President of the Pharmacological Society,
Hahnemann Medical College, Philadelphia.

LIST OF EXAMINERS.

General,	Dr. Charles Mohr.
Nervous System,	Dr. Weston D. Bayley.
Eye,	Dr. H. I. Jessup.
Ear, Nose and Throat,	Dr. I. G. Shallcross.
Circulatory and Respiratory Systems,	Dr. E. R. Snader.
Digestive System,	Dr. J. C. Guernsey.
Genito-Urinary System—Men,	Dr. Carl V. Vischer.
Genito-Urinary System—Women,	Dr. Theodore J. Gramm.
Cutaneous System,	Dr. Edward M. Gramm.
Pathological Products—Microscopical,	Dr. P. Sharples Hall.
Pathological Products—Chemical,	Dr. Charles Platt.
Animals,	Dr. W. E. Rotzell.
Pharmaceutical Products,	Eugene Parrat, Ph.G.

These are the general rules, and you see that they are important.

Each prover must fill up a blank or preliminary record, as follows:

PROVER'S PRELIMINARY RECORD.

Name,.....Residence,.....
Married or Single,.....Occupation,.....
Color, ...Sex,.....Age, ...
Height,.....Weight,.....
Constitution, inherited or acquired,.....
.....
Temperament, sanguine, nervous or lymphatic, ...
.....
Idiosyncrasies, mental or physical,.....
.....
Former diseases, ...
.....
Use of Stimulants,.....
Use of Narcotics,.....
Normal Pulse, Lying down,.....Sitting,..... .....Standing,.....
Normal respiration,.....
Normal Temperature, Morning,.....Evening,.....
Urine, habitual quantity and character,.....
.....
Stools, habitual condition,.....
Drug,.....

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This is filled out and filed with the Secretary of the Society. Before the prover receives the drug we, of course, determine what the drug to be proven is. If there is nothing detrimental in the condition of the man, as shown by a thorough physical examination, he is then given the drug within safe limits as to dose.

The idiosyncrasies, temperament, etc., are all taken into consideration. The drugs which we prove are analyzed by our chemist to see that they are pure, and then are analyzed by our pharmacist to corroborate the testimony of the chemist. Then the pharmacist experiments with the product to ascertain its solubility, etc., and to determine its best form for administration. Acetanilid, I will say, has been tried in the form of first decimal trituration tablets, saturated solution in alcohol (which represents one-sixth of the strength of the drug), and three, five and ten-grain powders. As soon as any effect followed, the drug was stopped altogether. The prover was watched and examined from time to time by our specialists to determine whether there was any indication of disturbance attributable to those pre-existing conditions that might give rise to subjective phenomena.

I want to say one thing in regard to the preliminary examination of these provers by specialists. We have examined sixteen students from head to foot, and I have particularly examined seven others, and of these gentlemen we found there was not a single one who was in absolutely good health; there was not a single individual who did not show about the eyes, nose, throat, circulatory system, respiratory system, digestive tract, or genito-urinary system, some pre-existing disease or the results thereof, conditions which at any time might give rise to various symptoms and be attributed to the action of the drug had their existence not been known. This shows the necessity for these examinations.

In regard to the dosage we have found that a certain effect would be produced by the first decimal trituration and the second decimal trituration, but after a time the repetition of these doses would be without any effect; then we would give larger doses, say one, three and five grains of the powder, when we

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would get an effect in many cases corroborating the effects of the first and second decimal triturations, but these larger doses would be followed by tolerance, so that the drug could be repeated in very large doses without the production of a single symptom. After the prover has rested for a month or so, we have found that the tolerance of the drug has worn off, and by giving small doses symptoms were again produced. Then, again, we had provers who have taken small doses, large doses, and frequently repeated doses without producing any effect whatever. One individual, who suffered from the effects on the circulation and heart, had to be watched with a great deal of care, and after the experimentation had ceased, we found that he had taken an aggregate of 278 grains of the drug. Our next experiments were made on rabbits, which corroborated the effects which had been produced by the action of the drug on man. Our next step was to gain knowledge of remedial action by the treatment of cases presenting themselves in our clinics. These patients are given this drug whenever their symptoms and conditions were like the effects elicited from our provings.

I want to say in conclusion, Mr. President and ladies and gentlemen, that this is a line of work which our Society ought to foster. We have shown you the difficulties in the way of conducting such experiments properly. We want many to engage in the work; we want it encouraged; we want these provings printed for distribution, first to the provers and second to the members of the Society and all other organizations who may be willing to test drugs. In the second place, I want to urge the members of our Society to organize provers' societies all over this State, that we may have correspondence with each other, that we may endeavor to reach a large number of individual experimenters, and thus improve our chances for better results.

Discussion.

Robert Hendel, M.D.: I recall to mind reading an account of the failure of a great many provings in Germany last year, no doubt due to the imperfect examination made of the provers. Unless you are particular about the conditions surrounding the provers it is impossible to get a correct proving.

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CHARLES MOHR, M.D.: I want to say a word in regard to the publication of the provings. It is questionable whether a proving can ever be complete. It seems impossible because of the exigencies, surroundings and susceptibilities that are constantly arising and changing, and which will make a proving somewhat different from that instituted before. When the provings of acetanilid are prepared for the press it will make fifty or sixty pages of the TRANSACTIONS. They ought to be published. Money could not be better spent by our Society.

A. P. BOWIE, M.D.: I think it a shame and a disgrace to this Society if a gentleman presents a paper showing the provings of a drug which is in daily and meritable use, as this proving tells us, that the Society should fail to take action upon such a paper. For my part, I would be willing to contribute something to have this paper printed in the TRANSACTIONS. For what are we here? For what is this Society but to learn and take advantage of such opportunities presented by this able article.

I approve of printing a set of provings, whether condensed or otherwise, as set forth in Dr. Mohr's paper. Here we have the original source of the proving, that is what we have been asking for for many years. We do not want a condensed materia medica; we need full and accurate records of provings, especially *new* provings, and then after years of clinical use we will know the characteristic symptoms, and then only can we condense.

EDWARD R. SNADER, M.D.: I am in favor of printing the provings, not necessarily in the TRANSACTIONS proper, but so that they are distributed among the members of this Society. Personally I am in favor of these provings, because they have been attended with such success, and we are never sure of our weapons under our old materia medica. I second the remarks of Dr. Bowie. What are we here for but to derive benefit and knowledge from just such papers? But do not let us now have a similar experience as we had with reportorial work some time ago, which occasioned a great deal of labor, and we all expected to have something very useful, but the Society threw it out altogether. If you want to annihilate this paper do so,

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but Dr. Mohr has given you a summary of what we propose to do, and, in my judgment, we cannot afford to throw cold water on work that promises so well.

The idea intended in the printing of the provers' records is to encourage the men who have done the proving. This is an element that must be looked to. We have had thirty-two offers from persons to act as provers, but only one-half responded. If we can accomplish this result without the printing, well and good. It will cost between fifty and sixty dollars to give this encouragement. I would suggest their preparation in a condensed form, if the Society does not wish to go into the major expense.

Z. T. MILLER, M.D.: In Dr. Hering's condensed schema there are some important drugs, such as arsenic, nux vomica, pulsatilla and such remedies, and yet not one of them covers fifty pages, or anything like it. If the provers in Philadelphia will hand to the State Society a schema of a drug in such a shape that it can be used, as in Dr. Hering's book, with the assertion back of it that these are reliable symptoms, the State Society will publish it every time, and every drug will receive this treatment; but whether it will be justifiable to introduce these provings is what I doubt—it would be a waste of money and time. If the men who stand at the head of the profession, whose word we respect, and whom we know to be of sound judgment, will state that such and such a drug is reliable, you can use it, etc., it will be published and paid for.

JOHN E. JAMES, M.D.: If we are going to refer this paper to the Publication Committee, there are officers on it who know what ought to go into print. I do not like the idea of instructing them. I am perfectly in favor of a motion to give to them the authority to review it and not "instruct" them. It ought to be tested by some other persons' judgment before going into print. I am willing to have the officers of this body revise it and say whether we ought to have it published or not. I do not consider that the forty or fifty dollars expense incurred should enter into the discussion.

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THE MATERIA MEDICA.

C. S. SCHWENK, M.D., PHILADELPHIA.

THE materia medica might be viewed as an album picturing distinctive forces, each capable of producing effects peculiarly its own, each performing its mission when summoned to execute the work singular to its individuality. This is either absolutely true or absolutely false.

What is your choice? If you are a scientist you must eventually accept one or the other, you can't take both. If they are true forces, then they are the uncompromising elements of nature, subject to no change, and must be accepted as a verity.

In this age of scepticism when the infidel gains prestige for heroic thought by subtle argument establishing agnosticism, which quietly flows through so many minds—arguments based on preconceived ideas seeking material out of which to construct edifices, refuting essentials to a homely but permanent structure in fear of marring architectural beauty and blasting fanciful conceptions—we naturally must expect the same influence to permeate the medical profession and tinge all observations with doubt, giving the appearance of an astuteness that would be sublime if it wasn't distorted.

When the patient gets well, the average homœopath appears to feel that it is incumbent upon him to immediately find an excuse for the recovery on any other grounds than the action of the indicated remedy.

The humblest personage may cry in defence, but the poor indicated remedy may be safely abused and have whatever opprobrium heaped upon it that the veriest tyro may choose. It may be accused of entire inability to produce any effect in a given case of sickness, and at the same time be guiltless of ever being near the case, but must suffer for the incompetency of a pretender masquerading in its place.

It is pertinent here to ask the question, "How often does the indicated remedy find its way to the sick?" The despairing

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cry arises, "How is the indicated remedy to be found in all the great mass of material published?" In one way, and in one way only, and that by therapeutics. A theosophical knowledge is not required; ordinary human intelligence is sufficient. Learn what a remedy can do, and then give it a chance to do it, but don't get lost in infatuation over results obtained, and run to seed with the idea that there is nothing that medicine cannot do. Diet, rest, water, alcohol and faith are of value to the sick, but when a remedy performs quick results it is scarcely fair to ascribe it to personal magnetism.

On the other hand, some contend that medicine plays no part whatever in the cure of the sick. Such administer medicine to their patients much as parents indulge children, because the traditional ideas of the sick demand drugging. But let us hasten by this, for it is dangerously near charlatanry.

We are just recovering from a decade of cyclonic medicine, wherein any idea, however chimerical, so long as it possessed the merit of being new, with a promoter who was a strategist, and, possessing a genius like Napoleon, could make double flank movements with the heavy guns of statistics, while down the centre charged all the old soldiers that had done duty on many another occasion, would win a brilliant victory for the author, whose songs of triumph rang from Germany, France and America to all parts of the earth, reverberating through the halls of medicine on down into our very barber-shops, journalistic notoriety, medals of honor, exciting comment by the press, and finally—the funeral.

Compare this tinselled grandeur to the significance of the simple truth expressed a century ago by one of the greatest minds in history, than whom no greater has ever stepped into the medical arena—OUR HAHNEMANN.

This was the beginning of the materia medica, which, by accretion, has grown to the enormous work of to-day, formidable indeed in its magnitude! Adopted by minds of variable elasticity, some content to walk in the footsteps of the author, while others stretched to the degree of breaking; indeed, some must have broken, for points of ascension were reached that could only be gained by severing all earthly ties. Spirituality was

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commonplace by comparison; then came reaction, homœopathy came back to the earth again, the pendulum swung to the other side, and slowly plowed through tinctures and fluidextracts, while many fell off and floundered amongst compounds, alkaloids and proprietary things; but the pendulum is swinging back to its centre, when will begin the renaissance of homœopathy heralded by the literature of to-day, and the old materia medica, unscathed by the storms of sophistry, ridicule and prejudice, passes on down into the future as a temple, reverenced by suffering humanity, bowing to the immortal genius who laid its corner-stone.

NOTES ON FERROCYANIDE OF POTASH.

WILLIAM G. DIETZ, M.D., HAZLETON.

My purpose in narrating the following cases is to call attention to a remedy which appears to be but rarely used by physicians of our school. The few provings, as recorded in the *Encyclopædia of Pure Materia Medica* (Allen), are fragmentary and contain but few symptoms suggestive of the conditions in which this remedy has proved itself so useful in my hands. The following symptoms, however, as found under "Nerves," in the Guiding Symptoms, I have found to be indicative, viz.: Paleness of lips, gums and whole skin, cold hands and feet, irregular, wandering, *neuralgic pains*. With these preliminary remarks I present the following cases for consideration:

Case I.—Mrs. H., æt. 23, farmer's wife and the mother of three children, was brought to me by her mother. Patient small in stature, anæmic, emaciated and weak. She has been told that she has incurable heart disease, and merely came in the hope that something might be done to relieve her pains. The beginning of her trouble she dates back from three to four years. Complains of a great deal of distress in the region of the heart; frequent attacks of pain which she describes as a severe ache with occasional sharp plunges. The pain is generally aggravated by moving about, or by any exertion, and re-

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lieved by keeping quiet, though occasionally the reverse is the case. The paroxysms are, as a rule, accompanied by palpitation of the heart, which occurs also independently of the pain. Mentally she is depressed, knows she has heart disease and that her days are numbered. Appetite, fitful; bowels, inclined to constipation. Urine, pale, voided rather frequently and increased in quantity; spec. gr. 1014; no abnormal constituents. No complaints referable to the reproductive organs. Inclined to chilliness, hands and feet cold. Has taken quantities of patent medicines. On physical examination could detect no signs of organic disease.

Gave her *kali ferrocyanicum* 1x gr. ii. three times daily. In about two weeks improvement was noticeable; continued the remedy for about four months, when she considered herself entirely well. Does her own work and has only occasionally a slight return of the pains, usually caused by overwork. The mental symptoms in this case correspond closely with those of the provings as recorded in the *Encyclopædia of Pure Materia Medica.*

Case II.—A. A., male, æt. 29, dark hair and eyes; rather spare. Always been suffering from a weak back, which he attributes to overwork as a boy. Rather nervous; complains of much sensation in lower limbs; easily tired and very much constipated, for which condition he has used Holl's treatment for a long time. One evening was sent for in haste; found patient suffering from an excruciating pain the region of the right kidney, extending downwards in the direction of the ureter; the pain was accompanied by retching, and the skin was bathed in a cold, clammy perspiration. Prescribed *lyc.*; the pain gradually subsided. Next day the patient felt quite weak, out of proportion, it seemed to me, to the length of the pain paroxysm. From this time on the paroxysms returned with increasing frequency, but varying in intensity and duration; when at all severe, they were accompanied by retraction of the testicles, but no urinary symptoms. This state of affairs continued for about five or six weeks, when the paroxysms changed their field of operation. The pain, instead of extending from its starting-point, along the ureter, would shoot along the border

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of the ribs (right side), being always very intense at a point corresponding to the site of the gall-bladder, thus simulating gall-stone colic; there was, however, at no time, an icteric appearance of the skin. By this time both patient and doctor were thoroughly discouraged. The pains would last a certain length of time, with or without medications; the latter had certainly failed to prevent the frequent recurrence of the paroxysms. I now prescribed *kali ferrocyan.*, under the continued use of which the pains gradually became less and less, until they ceased entirely.

CASE III.—Miss M.; æt 16. Very strong and large for her age; menstruation regular; inclined to melancholic moods, but otherwise appears to be in perfect health. Has complained for over a month of ill-defined wandering pains in the side of her chest, occurring day and night; no marked modalities; lachrymose and depressed when pain is severe. Examination proved lungs and heart healthy. *Puls.*, followed by *act. rae.*, gave some relief; *kali ferrocyan.* cured her promptly.

CASE IV.—Mrs. T.; æt 44; mother of two children; inclined to obesity; subject to attacks of severe cramping pain in epigastrium, with an empty, sinking feeling. Attacks generally occur about the time of the menses; the latter too frequent and profuse. Appetite and digestion not disturbed. *Sep.*, followed by *natr. m.*, would relieve the pains, but did not prevent their recurrence. Under the use of the *ferrocyanide of potash* she is now entirely free from the pains.

In conclusion I offer the following summary, the result of personal experience with the remedy in question:

1. Its principal usefulness in neuralgic affections, depending on an impoverished condition of the blood; or an exhausted condition of the nerve-centres, especially the spinal.

2. Reflex neuralgias, especially those of intrapelvic origin.

3. Its possible use in the neuralgic or rheumatic pains, depending on organic disease of the nerve-centres, such as locomotor ataxia.

4. To obtain good results the remedy must be given for some time. Not being an analgesic in the strict sense of the word, it rather cures than palliates, by removing the cause.

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REMEDIES PROVEN FOR THE HOMŒOPATHIC MATERIA MEDICA NOW IN USE IN THE OLD AND NEW SCHOOLS OF MEDICAL PRACTICE.

BUSHROD W. JAMES, M.D., PHILADELPHIA.

In accordance with a resolution which was passed by this Society at its last annual meeting, your committee has prepared a brief report upon a few of the remedies which, having been carefully proven by homœopathic practitioners and other observers, are now in use in both the old and new schools of medicine at the present day.

That which I understand to be a homœopathic remedy is one that has been submitted to a thorough process of proving upon the human system of two or more healthy individuals, who are possessed of sufficient intelligence to be able to report the numerous symptoms produced by the administration of the drug in its separate and independent action upon the healthy organism.

Old-school remedies are those which are not proven in this manner, but which are estimated in curative value either by their effects as noted in their action upon the sick or from observations made in toxicological cases induced by the drugs in question, and often the value is determined by the uncertain mode of giving it as a compound with other drugs, or in mixture with such.

Our subject is, therefore, limited altogether to the homœopathically-proven remedies, and the corresponding symptoms which provers have discovered while testing the drugs, and which have been adopted in the treatment of disease by the old school of practice for similar indications and conditions.

One of the most marked of the remedies under consideration is glonoinum or nitro-glycerine, which was discovered by Professor Sobrero, of Paris, who first published an account of it in 1847.

In December of the same year, 1847, Professor Constantine Hering, having had a small portion of the new article prepared

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for him by a reliable pharmaceutist in Philadelphia, made careful and very satisfactory provings of the remedy.

In 1848, Dr. Zumbrock, of Philadelphia, after making a number of experiments with the preparation, found a better and less difficult manner of obtaining it than that used by Professor Sobrero.

Our authority for this will be found in the appendix of Jahr and Bruner's *Pharmacopœia*, page 327. The same authority tells us that Professor Hering gave the name to the new remedy, composing it of gl o for oxyd of glycyl or glycerine, n o for nitric acid, and the determination ine.

From the *United States Dispensatory*, edition of 1883, page 1710, we quote: "Nitro-glycerine was discovered in the year 1847 by Professor Sobrero, of Turin. It was afterwards made a subject of study by Dr. de Vrij, of the Netherlands, Dr. Gladstone and Dr. Kopp, but did not attract much attention until 1864, when its capacities as an explosive agent became known." In the *Medical and Surgical Reports* for March 14, 1896, we find a paper by William C. Krause, M.D., for the *New York Medical Journal* (old school), February 29, 1896, in which he tells of using the new remedy, nitro-glycerine, for the treatment of sciatica with marked effect. He says: "From my experience I should advise beginning the treatment of sciatica with nitro-glycerine, and only after its inability to cure is apparent, falling back upon the other drugs and measures with which we are well acquainted."

Thus we find the use of glonoine entirely ignored by the old school from its discovery in 1847 until its use as an explosive in 1864, and mentioned as a "new remedy" by a number of old-school writers for several years past, and more recently by one of the old-school practitioners, in 1896, as quoted, while in point of fact the new school has been using it efficaciously in the treatment of numerous diseases ever since the late Dr. C. Hering of this city began his provings of the remedy in 1848. After him it was proved in rapid succession by Drs. Dudgeon, of London, Lippe, Okie, Jeanes, and many others in the United States of America, after which it became an established remedy in the homœopathic pharmacopœia.

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In Dr. Krause's paper regarding the use of glonoine, he remarks that the only discomforts arising from the use of this drug were congestive headaches and flushing of the face sometimes following the first dose of the medicine, while in others they did not supervene until the maximum doses were administered. To counteract these effects the bromides may be used, thus robbing the nitro-glycerine of all the physiological effects where they are not wanted, and allowing it to proceed without hindrance where it is needed.

The mistake of the old-school practitioners is that they prove the remedy on the afflicted, and cure these drug-symptoms in the poor, sick sufferer without knowing why.

Now, the homœopathic profession is observant of the peculiarly characteristic symptoms and beneficial properties of our carefully-prepared and proven drugs, when given according to the rule of art by which they are prescribed, but we have not yet arrived at that point of blindness that we cannot distinguish between the poisonous or probably the proving effects of a drug and its curative effect when attenuated. Hence we do not have to use the bromides to remove the effects of the nitro-glycerine, as does Dr. Krause. But if he can truly know and affirm that they met in an individual's system, decided upon the work they were expected to perform, and proceeded upon their several duties without further interference with each other or with the harmony of the human functions, we are given another field for experiment and research whose capacity must be found almost inexhaustible.

Dr. Krause might also learn from our doctrine that the "congestive headache and flushed face" are important provings of the remedy which might lead him to find still further use in attenuated preparations for it in his practice, instead of requiring him to counteract its poisonous influences in the innocent sick by antagonistic drugs.

Following the adoption of glonoine by the old school, we note that it is now administered in small doses, or divided doses, such as the $\frac{1}{100}$ or $\frac{1}{200}$ of a grain, as nux vomica, strychnia, and many other remedies now given by our old-school brethren.

Belladonna (atropia), deadly nightshade, has been used as a

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medicine from early times. The leaves were first used externally to discuss scirrhous tumors and to heal cancers and ill-conditioned ulcers, and were afterwards given internally for the same purpose. Much evidence of their influence in these afflictions is recorded, but this application of the remedy has fallen into disuse, and it is now more esteemed in nervous diseases. Belladonna has acquired considerable credit as a preventive of scarlatina, an application of the remedy first suggested by the author of the homœopathic doctrine, but the *United States Dispensatory* says it is absolutely devoid of any such power.

This attack upon his use of belladonna was met by Dr. Hahnemann, who explained that the so-called scarlet fever, upon which the tests of belladonna had been made by his enemies, was in reality purple rash, an altogether distinct disease, for which he used aconite, instead of belladonna, with satisfactory results.

Wood asserts that the "sole, active principle of belladonna (atropina) was discovered by Mein in 1831, and independently by Gieger and Hesse in 1833." He also expresses great faith in it as a remedy for the eyes, but cannot believe in it as a prophylactic for scarlatina; still it should be tried further, he thinks, before being laid aside.

Here again we see the use of a most valuable remedy ignored because it was not used by the old school until recently, whereas it has, from the beginning of its use by Hahnemann, held a very important place in the therapy of homœopathy, and to the provings made by prominent homœopathists the credit of its universal use in nervous diseases, and particularly in the treatment of the eye, must be attributed.

THUJA OCCIDENTALIS.—No radical cure had ever been discovered for sycosis until thuja oc. was proven and introduced into the homœopathic materia medica. When outward evidences of the malady appeared they were either cauterized or removed by the knife, and even then the results were only temporary relief, and not cure. During his researches Hahnemann found that the symptoms of the disease were so exactly produced by thuja occidentalis that he concluded that it was

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Nature's remedy. He joyfully announced, after having carefully proven the drug, that it not only prevented the outward growth, but accomplished an internal cure, thus finding it to be the radical cure so long desired of this condylomatous condition.

Notwithstanding this position and the unquestionable claim made by Hahnemann in his lesser writings and materia medica, the old school claims that Dr. Schoepf found thuja beneficial in coughs, scurvy, rheumatism, etc.; that Dr. Leaming, of New York, had used it with apparent efficacy in cancerous and venereal excresences, and that Dr. Benedict also used it as an emenagogue. All this about the years 1855 and 1859, but not one word is expressed to the credit of Hahnemann, whose writings, though scornfully treated, must nevertheless have been accepted as food for experiment, at least regarding this, as well as many other remedies.

CUPRUM.—"The chief internal use of cuprum is as a mechanical emetic. As an astringent and a stimulant it is occasionally given in pills in chronic diarrhœa, with ulceration. In small, repeated doses it has been used with doubtful advantage in nervous afflictions." Thus writes Prof. Wood in his *Therapeutics, Its Principles and Practice*, while Hahnemann showed by most earnest and careful proving and practice that it was the prime remedy for use in the second stage of Asiatic cholera. Until then, copper had been regarded and described only as a poison. His irrefutable success in its use could not but leave some degree of impression upon his professional mind, and we do not doubt that even the slight tribute to its worth as a curative power is attributable, though unacknowledged, to Hahnemann's wonderful success in treating this scourge with it when indicated.

The reason why this remedy did not find so much favor in old-school hands for the nervous and spasmodic symptoms, such as cramps, was probably due to the fact that it was administered in proving-doses or in excessive quantities, so as to produce in the patient the aggravated symptoms of the drug itself.

SANGUINARIA CANADENSIS.—Two asserted alkaloids discov-

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ered by Dr. Dana, in 1829, and named by him and identified with chelidonium majus—chelerythine; another form was discovered by Probst in 1839, used as an emetic, but better as a stimulating expectorant in obstinate bronchitis, even then with doubtful advantage, Wood states.

But we find sanguinaria canadensis proven and introduced as a Homœopathic remedy in 1803, by Dr. Downy, and authorized or proven by Hering, Tully, Pilling, Freitag and others, while it holds a prominent place in Dr. Hale's "Characteristics of New Remedies," whose third edition was published in 1873.

IPECACUANHA "was discovered by Piso in 1649. It has been enormously used in Europe since 1672. Its physiological action is not yet made out. It has been mostly used as an emetic. It has been supposed by some that the drug acts upon the vaso-motor system. Tonic doses paralyze the heart. Therapeutic doses may probably have no decided direct effect upon the circulation," says Wood.

Against this very dubious handling of a drug we have Hahnemann's very succinct descriptions of its therapeutic uses; physiologically in the treatment of nausea; in the second, morbid conditions occurring during the course of scarlet fever, and in its dynamic power in giving relief by outward application.

The old school still makes use of ipecacuanha as well as the new school. Is it not more than possible that the peculiarly effectual use of it by Hahnemann and his followers has excited the necessity for searching into its therapeutic nature and broadened the knowledge requisite for its proper use?

NUX VOMICA.—Strychnos nux vomica, Linn., has been to Homœopathy as one of the first valuable drugs proved by Hahnemann. Fleming, F. Hahnemann, Stappe, Wahle, Bergens, Hughes and a great number of other prominent homœopaths made careful provings.

Nux vomica and strychnia are used by the old school to a considerable degree in treating palsy, paralysis and kindred diseases, and it is used in the form of strychnine in atrophy of the optic nerve. (See Wood.)

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The old school claim its chief alkaloids, strychnine, brucine and igasunne, as possessed of the only truly medicinal qualities. Homœopathy makes officinal preparations from tincture of the root and triturations of the dried root, and makes a separate remedy, called strychnia, from the alkaloid of nux vomica particularly, and sometimes from other species of strychnos. It is prepared by triturating the alkaloid, or making a solution of the salts.

Noack and Trinks name as provers of strychnia, Andral, Herl, Richter, Burdoch and a number of other physicians.

NAJA TRIPUDIENS has been mentioned as a late addition to the old-school pharmacopœia, but we find no reference to it either in the *United States Dispensatory* or in Wood's *Therapeutics*. But it has been a homœopathic remedy since its provings by Dr. Stokes in 1853. It was also proved by Drs. Russel, Craig, A. C. Pope, Drysdale and others, and its characteristics are noted in Dr. E. M. Hale's *Characteristics of Remedies*, published in 1873. It is officinal, both in tinctures and triturations of the virus from the cobra di capella.

SEPIA.—Another remedy new to the dominant school, and not mentioned either in the *United States Dispensatory* or Wood's *Therapeutics*, is sepia, proven or authorized by Hahnemann, Gersdoff, Goullon, Gross, Hartlaub, Wahle and several others. The medical preparation from the dried black liquid of the "ink-bag" of the cuttle-fish is named only as a color used in water-colors, in the *United States Dispensatory*. Whether the drug has found its way into the old-school practice or the information has been misconstrued we cannot say, but of its use in new practice we have been cognizant for many years.

RHUS TOXICODENDRON.—The officinal preparation is prepared by making a tincture of the plant. This drug holds a place in Barton's collection for the materia medica, 1795, and it was proven by Hahnemann, who used it very successfully in typhus and typhoid fevers, and following Cuprum in the treatment of Asiatic cholera. Drs. Franz, Hartlaub, Trinke, Du Fresny, Berridge and others either proved or authorized its use.

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Wood says, "The leaves of rhus toxicodendron seem to be stimulant and narcotic. They have been used in palsy, cutaneous diseases, etc., with asserted success, but the practice has found no recent imitators, and the remedy is a dangerous and probably useless one." Probably homœopathy has never received a more decided repudiation than this, and Dr. Wood's total neglect of mentioning the preparation. Yet not only does it remain a standard remedy in the new school, but at last its properties are found of sufficient importance to be added to some of the mixtures used in dominant practices.

MERCURIUS in its several forms has long been considered a sovereign remedy by old-school practitioners, but we rather doubt if mercurius solubilis Hahnemanni, a remedy discovered by Dr. Samuel Hahnemann, who was an excellent chemist, has yet found its way into the sacred precincts prescribed by their school, though we find it so credited by one writer. Perhaps his pen has slipped, as all other preparations have their place in old-school lists of drugs. The various mercury remedies have been proven by homœopathists and introduced into the proven materia medica.

CALCAREA CARBONICA (Calcium Carbonate) is no doubt the remedy which old-school practice claims to be analogous to its calcii carbonas precipitatus; but the homœopathic preparations made for Hahnemann by triturating the inner layer of the oyster-shell cannot be looked upon as the same as that made by a mixture of distilled water, chloride of calcium and carbonate of soda, the precipitate being washed in warm water until the washings cease to give off a precipitate with nitrate of silver, as per formula in *United States Dispensatory*. The simple trituration of the shell was used by Hahnemann, whose co-authorities are Franz, Gross, Hartmann, Langhammer, Fincke and several others. Dr. Koch's preparation was obtained by precipitating carbonate of lime from a solution of chalk in hydrochloric acid, the precipitate being triturated with an equal quantity of sugar of milk. Twenty parts of this mixed with one part of alcohol is called the tincture, which we must confess is rather a misnomer, as the result is really a milky liquid, which rapidly precipitates the calcareous part of the solution.

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SPONGIA TOSTA is homœopathically prepared by digesting twenty grains of powdered sponge, that has been roasted brown, with 400 drops of alcohol.

This preparation was tested and authorized by Dr. Samuel Hahnemann, F. Hahnemann, Gutman, Hartmann, Haynal and others of repute in the homœopathic proving of remedies.

The remedy is not mentioned in *Wood's Practice*, but the *United States Dispensatory* gives a succinct description of its preparation and use. As if led by a consistent spirit of contrariety, the officinal preparation, spongia tosta, is used in a powder instead of a tincture.

HEPAR SULPHURIS CALCAREUM is homœopathically prepared by conjoining the inner coat of oyster-shells and pure flowers of sulphur, and making triturations from the product. This drug was known and authorized by Hahnemann, Stapf, Fincke, Robinson and others, who used it internally for the cure of the symptoms of croup and itch, and to counteract the indications that follow this evil.

The *United States Dispensatory*, after giving an elaborate description of the preparation of this drug, says "it is efficacious in cutaneous diseases, in chronic rheumatism and gout. It has also been given in painters' colic, asthma, and chronic catarrh, having also attained a short-lived reputation as a remedy in croup after the publication of the essay to which the prize offered by Napoleon for the best dissertation on that disease was awarded." In reality, since the days of Hahnemann hepar sulphuris calcareum has been one of the prime remedies for croup, and it is to-day.

SPONGIA has many croup symptoms among its characteristics, and so has aconitum napellus.

We have thus made but cursory mention of some of the prominent remedies, which, by their peculiar efficacy in their different symptoms, have become standard homœopathic remedies, and which have been well proven upon the healthy human system.

We have not the least desire to retain them exclusively in our school, but, in justice to the earnest students and honest practitioners who have from time to time used their own sys-

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tems, or the systems of other healthy individuals, both male and female, upon which to prove the characteristic actions of the drugs in our pharmacopœia, we think that credit should be claimed where it is not fully given by those who use them and who have not worked out their indications, except upon the sick, clinically.

It is a well-known fact that the drugs used by the dominant school are not proven; that is, they are not submitted to positive practical trial by provings before they are placed for use upon the market. To a certain extent their properties are known, or guessed at, by empirical tests on people who are suffering with the diseases seeming to require the aid of remedies.

The time for fun-making criticism of homœopathy by our professional opponents has about passed away, and the laity has recognized the reform in medicine which homœopathy has brought about. The battles for the administration of homœopathically-proven remedies upon the rule of art or law of cure, as known by the expression *Similia similibus curantur*—the small dose, or divided dose, as our old-school brethren now put it—and also the general use of the single remedy as against compounds and mixtures—have all been fought out and won by the new or reform school of medicine.

I have been informed that many of our remedies are now purchased direct from homœopathic pharmacies by old-school physicians, but the cures affected, however, are not reported in their journals as cures made by homœopathic remedies.

Let the homœopathic system have credit for its value in medical reform, but do not use the mixed preparations, or quack preparations called homœpathic specifics, as the genuine, proven, individual drug.

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REPORT OF THE BUREAU OF OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

Homœopathy vs. Allopathy in the Treatment of Injuries of the Eyes, by W. H. Lee, M.D.
What Should be the Aim of the Refractionist, by W. H. Bigler, M.D.
Chronic Hypertrophic Rhinitis, by C. H. Lee, M.D.
Ophthalmia Neonatorum, by H. F. Schantz, M.D.
Orificial Surgery with Relation to the Nasal Reflexes, by W. G. Steele, M.D.

HOMŒOPATHY VS. ALLOPATHY IN THE TREATMENT OF INJURIES OF THE EYES.

W. H. LEE, M.D., O. ET A., NEW CASTLE.

It certainly must be very gratifying to us as homœopathic physicians to be able to say that we can cure this or that disease by internal treatment; that the knife is not always necessary to completely remove an abnormal growth, or to combat a sympathetic inflammation the result of an injury. How many times have we heard that Dr. Allopath intended to enucleate an injured eye, fearing sympathetic inflammation in the other, in a few hours after the wound had been received? What have they to counteract an inflammation? Practically nothing. The thoughts of having to submit to the use of the knife will often make the bravest of men shrink, and ask how long will it be before an operation would be useless? Wise and thoughtful friends say Dr. Homœopath does not cut every time he sees a case, and the patient hastens to the new- and successful-school doctor, who tells him he can be cured by medicine, and knows, if he is truthful, that it can be done. Haven't some or all of us had just such cases to treat?

The above is an introduction to a few cases that have ter-

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minated very favorably, and are of a more serious nature than were treated upon in my paper before this Society in 1894.

CASE I.—Injured by a chip of steel cutting through cornea and iris, extending from limbus toward pupil, being one-fourth of an inch in extent, permitting the iris to prolapse as well as the escape of the aqueous. He was seen in a very few minutes after the accident by an allopathic specialist, who said the eye would have to come out immediately, so that the other one might be saved. This the patient objected to, and two days later consulted me at New Castle. By this time the eye presented very alarming symptoms, with some sympathetic inflammation appearing in the other eye. At his request I was to try to save the ball, even if sight should be lost. He is to-day still carrying the eye, and although sight is *nil*, it is much better looking than an artificial one. This was five years ago.

CASE II.—Eye was punctured by a tine of a manure fork, no doubt loaded with bacteria, near centre of cornea, and emerging between the insertions of the superior and internal recti. The cornea was considerably torn, a large portion of iris prolapsed, and an escape of both aqueous and vitreous humor. Being a child of about five years of age, considerable trouble was experienced in keeping on compresses and him in a recumbent position. The torn portion of cornea was slow to heal on account of suppuration, but was kept well under control. Several weeks after injury the case was discharged, being blind, but an eye that looked very well and answered all purposes, except seeing.

CASE III.—Had sight destroyed thirty years ago by cornea being scratched by a piece of wheat-straw. He consulted me three years ago for a recent injury caused by the point of a tack tearing the sclerosed cornea while shaking carpet. When the case was seen by me two weeks later it had almost reached the stage of panophthalmitis. He was told by his allopathic physician that the eye should be enucleated, but he wished me to "experiment," and, if possible, save the ball. A short time ago he told me the old white eye served him better than either an empty orbit or an artificial eye.

CASE IV.—Is an exact counterpart of Case I. as to how injury occurred, its location, etc., except I saw it about thirty

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minutes after the accident happened. The result was the same as the three preceding cases.

CASE V.—Had lower lid cut by glass, beginning one-half inch below external canthus, penetrating the lid as far across as the internal canthus. The eye was evidently turned up and in at the time the accident happened, as the wound extended from the equator up and in the internal corneo-scleral junction. Considerable vitreous and aqueous humor escaped, prolapse of iris, which was torn, and lens-capsule ruptured. A more unpromising case would be hard to conceive, especially in a boy of four years of age with a nervous, excitable temperament. The result of this case is also like the others—blind, but still retaining the ball, with more or less opacity.

The above shows conclusively what homœopathic treatment will do for injuries to the eyes. I cannot say if they will have trouble with the injured eye in the future or not, but it is more pleasing to look at an eye that Nature put there, even if it is blind, and a pretty tolerably clear cornea, than an empty orbit or an artificial one. You may ask to what was due my success? A very short but nevertheless true answer would be, to treat the eye just the same as any other injured or diseased portion of the body by using the indicated remedy. Care should be taken regarding the iris. If any of it is prolapsed, that portion should be cut off, and then drawn back into the aqueous chamber by the instillation of eserine if the wound is toward the external border; atropine, if toward centre of cornea. In Case IV., eserine and atropine were used—one in the morning, the other in the evening. I found if but one was used there was a tendency for the iris to adhere to the cornea, so concluded to keep the iris on the move till all danger of adhering had passed.

The principal remedies for internal use were aconite, bryonia, arnica, ferrum phos., hamamelis, gelsemium, ledum, rhus tox. Externally, cold compresses of succus calendula, hamamelis. I know of no better remedy than the fluidextract of hamamelis in water for compress and hamamelis internally to absorb intraocular hæmorrhage. I generally use twenty drops of the fluidextract to a pint of water; the recumbent position must be insisted upon, and the bowels kept well open, as much straining will usually open the wound on the ball.

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WHAT SHOULD BE THE AIM OF THE REFRACTIONIST?

W. H. BIGLER, M.D., PHILADELPHIA.

In view of the prominence given to the various ailments traceable and traced to the errors of refraction, I feel justified in regarding the treatment of these errors as a very important part of the duty of the oculist, and the refractionist as by no means an insignificant species of that genus of specialist. If he would rise above the optician and elevate his profession above that of the mere fitter of glasses, he must set before himself distinctly a definite aim in his treatment by the complete or partial, temporary or permanent, correction of errors through glasses.

In speaking of the subject of correction of errors of refraction we must remember the difference between relieving the symptoms resulting in consequence of an existing error, and curing the error itself, and restoring the eye to a normal condition. The former is always possible, the latter rarely, if ever.

In studying the subject of refraction in our patients we are struck with the frequency with which we find whole families presenting some form or other of faulty refraction in each member, not of necessity the same in all. We are readily brought to recognize the influence of heredity and environment in their production. There are, it is true, some cases, a comparatively small proportion of the whole number, where the condition can neither be traced to immediate or remote ancestry, nor ascribed to the circumstances or condition of the patient.

The symptoms for the relief of which the oculist is usually consulted are in the fewer number of cases directly referable to the eyes. They may be obstinate headaches, resisting all treatment, but not necessarily above the eyes, rather in the temples or behind the ears or in the occiput, as is usually the case in astigmatism. Congested or scaly margins of the lids may be the only complaint, or general nervousness, sometimes with

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choreic movements, may bring the patient to the oculist. Because we find these or other symptoms coincident with errors of refraction we must beware of at once and dogmatically considering these latter as their direct and sole cause. The mistake is often made of promising relief from all symptoms when the error of refraction is but one of a number of contributing causes. For example, we often find headaches resulting from eye strain combined with neuralgic headaches or true migraine. The correction of the refraction will not cure any but the headache dependent upon it, although the general condition of the patient will be by just that much improved.

Again, the so-called asthenopic symptoms, direct or reflex, need not and seldom do result from anything which in itself can be regarded as abnormal in any of the refracting media, since a true form which shall be applicable to all eyes cannot be established, but the trouble lies in the faulty relationship between them. Thus, in a case of myopia we cannot say that the lens is absolutely too convex, or that the ball is absolutely too long, but only that that particular lens has too short a focus for that particular ball. So also in a case of hyperopia, the focus of the lens is too long for the ball in which it occurs. Nature has endeavored in each case to provide means, instinctively called into play, to restore a proper relationship in the hyperope by relaxing the suspensory ligament of the lens through the action of the ciliary muscle, and allowing the lens to become more convex; and in the myope by bringing the lids together so as to cut off the rays of diffusion and allow only the direct ones to reach the retina, thus providing for clearer vision in both cases. In astigmatism we find either one or both of these means used according to the character of the astigmatism, together with a tilting of the head so as to employ the palpebral opening as a stenopaic slit and in this way to obtain distinct vision.

Nature in providing these means has not in all cases adapted the rest of the system to their easy and successful employment. In some, for example, we find a high degree of hyperopia overcome for years without discomfort, in fact without recognition, until sickness or age has weakened the power of the parts con-

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cerned, and the increased effort rendered necessary becomes irksome and symptoms arise. In others, on the contrary, a very trifling degree of ametropia is sufficient to produce distressing and widely-reflected consequences. We must remember that disability, a result of sickness or unfavorable environments, may be but temporary, spontaneously disappearing with the general debility in which it had its origin.

Again, we can distinguish between symptoms which arise from the efforts made to overcome errors of refraction and those which are due to the want of success attending these efforts. We will find that the nearer these efforts are to being successful, without being entirely so, the more likely we are to find urgent reflected or nervous symptoms. A o, 25D of ametropia incapable of being overcome by natural means is more likely to result in vague symptoms of nervousness than are 2D of a similar uncorrectable error to produce symptoms of so-called asthenopia.

One more consideration before answering the question proposed, and within which lies, we think, the key-note to the whole. All organs and functions which we possess are maintained and strengthened by use, while disuse serves only to weaken them and eventually to render them powerless. This law can be traced throughout the whole history of evolution in the appearance and disappearance of functions and organs according to the changes in environment. Absolute rest or cessation from exertion results in a gradual but certain loss of function and suppression of the organ or organs concerned in its exercise. This weakening of power can be noted as the result of but a very short period of suspended activity, as in the artificial ptosis produced by prolonged bandaging of an eye, and many other examples which could be cited.

We are now in a condition to answer our question. The aim of the refractionist should be, in each case, to give nature only that assistance, by glasses or otherwise, as shall enable the patient to use the eyes without discomfort, at the same time that the functional powers of the eyes are strengthened and preserved, and not weakened by removing the necessity for exertion.

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This may seem quite natural and proper, and even commonplace, but it is by no means the general practice, and in what respects this frequently differs will be seen when we now, in conclusion, enumerate the points which are included in this general statement:

1. Individualizing of all cases. Each case will be treated on its own merits. There will be no rules as to the proportional amount of the error which is to be corrected by glasses, as, for example, was formerly prescribed, "all of the Hm and ¼ Hl."

2. The discovery of the total amount of ametropia, whether myopia or hyperopia, by the use of a mydriatic—in our estimation the only reliable means. Apparent myopia will, under the use of a mydriatic, often prove to be the result of spasm of the accommodation, and, therefore, age should be the only circumstance to deter us from the use of a mydriatic.

3. A regard to hereditary influences. A child of a myopic parent will be likely to develop progressive myopia, unless it be held in check by the most carefully-prescribed glasses, and regulated use of the eyes. Such a case will be apt to require a fuller correction than another.

4. Most careful consideration of the circumstances and condition of the patient. The temporary or permanent character of the causes of the asthenopic symptoms will greatly influence the line of treatment. A post-diphtheritic paralysis of the accommodation in a child will require a different method, even with glasses, from the failure of accommodation in an aged person, although the total error may in both cases be measured by the same strength of lens. Asthenopic symptoms in a convalescent may require no change of glasses if complete restoration to health is in sight.

5. A careful estimation of the amount of effort which the unaided eye is capable of making without discomfort. Under no circumstances should that be interfered with, or the necessity for its being called into play be lessened. Rather encourage greater exertion of the parts concerned in vision than relieve them of their duty. Disuse is as bad as disease.

6. A careful study of the whole constitution of the patient, and a discovery of the immediate cause of the inability to use harmoniously the various parts of the visual apparatus.

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7. The courage to refuse to prescribe glasses, or a change of glasses, even in presence of an error of refraction and asthenopic symptoms, provided the ultimate condition of the patient and his eyes will thereby be best subserved.

Whoever has become acquainted, practically and in his own person, with the inconveniences and worry inseparably connected with the continuous use of spectacles, will not despise nor neglect the advantages to be gained by attention to the above points. It will often render it possible for a patient, after the use of glasses for some time, to lay them aside entirely for a varying period, the length of which frequently lies distinctly within the power of the family physician to control. Even if this cannot be accomplished, the strength of the lenses used will not have to be changed so frequently, nor increased so rapidly; a result, however, more conducive to the comfort of the patient and to the reputation of the oculist than to the profit of the optician.

Discussion.

A. B. Norton, M.D.: The interesting paper of Dr. Bigler is one that I can endorse in many respects. The importance of careful refractory work cannot be overlooked. Its relation to diseases to which he has called attention is very close. I think, however, that all specialists are apt to go to extremes in regard to this subject, and think that all headaches result from eye defects. While I believe that a portion are the result of such defects, certainly all are not. I think it is the duty of every practitioner, when he has a case of obstinate headache, before sending them to a specialist to have their eyes examined, to make a preliminary examination of them himself, in his office, with a test card, so that he can find out whether the vision is correct or not; and, if he is not prepared to adjust glasses himself, he can then refer them to some specialist. I do not believe that it is safe for a general practitioner to attempt to fit glasses to any person's eyes unless he has had considerable experience. We are having in New York State, at present, great trouble with this very subject. Certain opticians, who are incompetent, are trying to get our Legislature to pass a law legalizing them to fit glasses to patients. This is wrong, as there are too many

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things to be taken into consideration, and no one outside of a physician should write a prescription for a pair of glasses. There are many diseases aggravated by the improper use of glasses, and this makes it important for the interior of the eye to be carefully examined by a competent physician. The matter of fitting glasses to children is another extreme. We are seeing too many children wearing glasses, and the matter is being overdone in many instances. Many of these children have headaches which could be relieved by other treatment. I make it a point never to prescribe glasses until I ascertain whether the muscular bounds of the eye are perfect. The strain occasioned here is the cause of many reflex manifestations. These muscular troubles can be relieved by treatment in other ways. There is no doubt, however, that the eyesight of young children is deteriorating. Statistics have proven, particularly in German schools, that advanced civilization is causing greater strain upon the eyes than formerly. In Germany, in primary schools, of the children whose eyes were examined, 15 to 20 per cent. were found to have myopia. In the higher grades, 30 to 40 per cent., and in the colleges, 75 to 80 per cent. Now, a great many of these cases could have been prevented by careful examination early in life, followed by proper correction. It is just as important for children to be examined regularly, early in life, by an oculist as it is to send them regularly to the dentist to have their teeth attended to. Many near-sighted people, who are now wearing glasses, could have had all that prevented by proper attention to the eyes in early life. As far as the use of remedies is concerned, no defect can be cured by drugs—you must use glasses.

BUSHROD W. JAMES, M.D.: This is a matter of great importance. I have been astonished to see how small an amount of astigmatism will cause headaches, nervousness and other reflex symptoms. This is especially noticed in school children, where the eyes are used constantly during the day and considerably at night. Formerly I used to ignore some of the cases of slight astigmatism coming to my notice; but now I work them all out with the greatest care and precision, and have been rewarded by getting very satisfactory results. Some-

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times the defect has been so slight that I have hardly thought it worth while to fit a pair of glasses; but I have seen so much benefit derived from a weak pair that I almost invariably advocate their use.

In addition to testing with the test-card I work out these cases with the ophthalmoscope, and I make a record of what this instrument shows me in regard to the refraction. It is a habit I have fallen into, and I always take the combination of these two tests as a basis for my diagnosis. I am simply adding to the plea for careful refraction the use of the ophthalmoscope, as it enables you to confirm your diagnosis with the test-card.

In regard to the cases spoken of by Dr. Norton, of troublesome refractions, you will find the patient's energies taxed by loss of rest and the carrying on of a large social line of fashionable enjoyment in combination with their everyday work, and it is in these cases that the greatest amount of muscular deviation and unbalancing is found. You may test these cases and find an indication for the use of glasses; but that remedy which does the most good is complete relaxation and rest of the nervous system. Medical treatment is also very important, and I think the specialists present will agree with me in that respect.

I was glad to hear Dr. Norton speak of the deterioration of the eyesight at the present day, due largely to the overwork of the nervous system, and that he advocates the advising of nervous and physical rest to ameliorate all asthenopias, headaches, etc.

WILLIAM H. BIGLER, M.D.: The subject of my paper was suggested by the experience that I have had in finding that the general practitioner is apt to expect too much from the oculist. He often fails to recognize the fact that the error of refraction is but one of many contributing causes in the production of headaches, nervous symptoms, etc., which he has been treating unsuccessfully, and that therefore the oculist cannot be expected to remove them all by his treatment. I quite agree with Dr. James that other things have to be taken into consideration besides the mere correction of an error of

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refraction in the treatment of the eyes, such as nervous and physical rest. There is no doubt that there is an increase of refractive errors in children at the present day. In my experience the cases of myopia in children are much less frequent than those of hyperopia. In Germany myopia is constantly on the increase, and when a child of German parents is brought to me I am very particular in my instructions as to the use of his eyes so as to prevent if possible the occurrence of progressive myopia, to which I recognize that he is predisposed by heredity. By following out the principles of my paper I frequently prescribe glasses for hyperopia, which, after a time, can be laid aside and need not be worn again for years.

Dr. James referred to the systemic remedies used. That is just what my paper calls for; they put nature in a condition to do what she wishes to do, and therefore I insist that the constitution of the patient must be taken into consideration. For the last twenty years I have been treating errors of refraction, and in everything that I have said and done I have insisted that the specialist is *under* the general practitioner. He is only a specialized organ in the body medical, and his function is only to be exercised for the benefit of the whole. The point in my paper was particularly to make the specialist feel that it is not a question of testing refraction alone, but testing the individual, his constitutional traits, etc., and to assist nature's efforts, not to supplant them in his treatment. I thank you for the discussion and for the interest manifested in my paper.

CHRONIC HYPERTROPHIC RHINITIS—A FEW CASES.

C. H. LEE, M.D., NEW CASTLE, PA.

THIS is a chronic inflammatory condition of the mucous membrane of the nose, which is no doubt caused by frequent attacks of the acute form. The patient complains in different ways; some have asthma or headache, or neuralgic pains in

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the eyes, dimness of vision, acne on the nose, etc. By making an examination of the nose with the speculum you will find the turbinates (one or more) enlarged, the inferior turbinate more frequently than the others. The membranes are dark red. Upon touching it with a probe it feels hard, and on pressure it leaves an indentation which is slow to return to its former position; also by the use of cocaine the membrane shrinks but very little, while in vasomotor rhinitis the membrane will shrink quite perceptibly. With these preliminary remarks I give a few cases.

CASE I.—Mrs. S.; age, 28; went to an oculist for the following symptoms: Dimness of vision; could not see to read or sew; at times shooting pains between the eyes. She was fitted three different times with glasses, but all to no purpose, her eyes getting worse and giving her more pain. The doctor said she must wear them and her eyes would come all right; but wearing the glasses only made the trouble worse. She was advised to see my son, Dr. W. H. Lee, the oculist. He examined the eyes and found no trouble, but said it was reflex from some other cause. She was referred to me, and upon examining the nose I found both middle turbinated bones hypertrophied and pressing upwards against the septum. Touching the hypertrophy with a probe, it caused her to have the same shooting pains in the eyes. There was a slight discharge of light, straw-colored mucus from the nose. Believing this to be the cause of the trouble I applied cocaine and cauterized the hypertrophy with chromic acid and gave kali bic., 3d, internally, which in time made a perfect cure.

CASE II.—Mr. H.; age, 30; farmer; for six months past complained of having asthma; could scarcely do his work or walk fast, especially walking up hill; does not complain of any pain; no cough; lungs and heart normal; as long as he keeps quiet and rests he has no trouble. Examined nose; found hypertrophy of both inferior turbinates, which almost closed the nostrils. Gave him solution of bicarbonate of soda, to be sprayed up the nose night and morning, and kali bi., 3d, every three hours, for one week; cauterized the hypertrophy, after which a solution of boracic acid to be sprayed up the nose,

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and continued kali bi., 3d. In four weeks he was entirely relieved of the trouble.

CASE III.—Willie S.; age, 8; post-nasal catarrh, with hypertrophy of both inferior turbinates, nearly closing the nose; also has adenoid growths, with yellow mucous discharge dropping in the throat; does not sleep well; snores; in his sleep mouth wide open. Gave bicarb. soda in solution, to be sprayed up the nose night and morning, hepar s., 6, every three hours. In a week cauterized the hypertrophy and applied Seiler's solution to the adenoid growths every third day and kali bi., 3d. In two months he was well.

CASE IV.—Miss A.; age, 17; complained of frontal headache; astigmatism; post-nasal catarrh; she could not study well while at school; memory weak. Astigmatism was corrected with glasses. Examination of nose showed hypertrophy of inferior turbinates, and post-nasal examination revealed hypertrophy of the pharyngeal tonsils or adenoid vegetations which secreted an excessive quantity of mucus or muco-pus, which also changed her voice; defective hearing. I preferred to curette the pharyngeal vault, but she would not allow me. I gave her kali bi., 3d, every three hours, and used iodine and tannin on cotton, applied to nose and post-nasal space, every third day. Result was that in two months the vault was clear of all vegetation; hypertrophy of turbinates reduced to their normal condition.

CASE V.—Rev. S.; complained of weakness of vision of left eye; no headache; slight discharge of yellow mucus, dropping back into the throat; roaring noise in left ear; slight hypertrophy of left inferior turbinate, and large spur on left of septum. Removed spur with the saw; cauterized the hypertrophy; gave kali bi., 3d. Treatment resulted in perfect vision; roaring in the ear and mucus discharge ceased.

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OPHTHALMIA NEONATORUM.

H. F. SCHANTZ, M.D., READING, PA.

THE general cry to-day is, "Give us something new." In politics new theories are advanced to catch votes. In medicine we advance theories in the hope of finding some new means of preventing or curing disease. The subject of this paper is not a new theory of treatment nor a new disease, but the consideration of one of that old, stubborn class of diseases whose results are frequently serious, and the consideration of which is often avoided, because—well, because it is an old subject, and men prefer to consider "new things." As the effects of some remedies are more marked when applied by inunction, so, many things in medicine are remembered only after they have been "rubbed in" time and again, and then their importance is noted. I desire to "rub in" a few thoughts on ophthalmia neonatorum.

The study of the inflammations of the eyes of the new-born is important on account of the danger of the incurable eye affections, and in many cases the total blindness which follows the attack. The hardships which blindness, or even vision partially impaired by a corneal haze, entails on the future of the little sufferer are such as to make us cautious in the diagnosis and treatment of this class of cases.

Ophthalmia neonatorum can always be traced to infection at birth from a purulent or muco-purulent discharge from the vagina of the mother; not necessarily a gonorrhœal discharge, but even a simple leucorrhœa, or what is clinically considered such, may cause it.

Subsequent to birth, the careless use of soiled towels or the dirty hands of the attendant may bring the contagium into contact with the sensitive conjunctiva of the infant. Face presentations and retarded labors predispose to the disease, for the discharge may be forced into the conjunctival sac while the

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head is descending through the parturient canal. The most dangerous time, however, is when the head is born and the infant first opens its eyes.

The disease usually develops on the second to the fourth day after delivery. If later, it is more probably due to infection subsequent to the labor. Both eyes are usually affected, but not at the same time nor with the same severity of attack.

Many of us can recall seeing a case with only a slight redness of the lid-edge, and a scanty discharge at the inner canthus, the babe lying with eyes closed because the light is distressing. The nurse calls our attention to the condition, but we may pass it by lightly, thinking it is only a symptom of a slight cold or "changed surroundings." Next day we call and find the lids have swollen rapidly, and are thick and brawny, and the purple veins are prominent. We now begin to realize that we have something serious on hand. If we institute prompt and careful treatment we may yet check the disease. On separating the lids the thick, yellow pus wells out, and is so profuse as to hide the cornea, which lies at the bottom of the space surrounded by the thick wall of chemosis. The danger which confronts us is involvement of the cornea; the anterior vessels of the eye-ball may be strangulated by the chemosis, the pressure of the thick and brawny lids and purulent infiltration into the parenchyma of the cornea, with the resulting circumscribed superficial ulceration, and later perforation, and possibly anterior synechia or adherent leucoma; all form a picture to be looked for in these cases of inflamed eyes in infants.

This picture may be even worse. The perforation of the cornea may be followed by a cyclitis, choroiditis, or a panophthalmitis, which latter entirely destroys the eye as an organ of sight, and our poor little patient is doomed.

The prognosis in these cases must always be guarded. The gravity increases in proportion to the extent of involvement of the cornea. Dr. Guernsey, in referring to the conditions, says: "The disorder is always serious, for unless speedily cured, which is not always easy to effect, the inflammation will result in opacity of cornea, impaired vision, or even total blindness."

The fact of this disease being the most common cause of

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blindness is to be deprecated all the more, because the results of the disease may be greatly modified if intelligent treatment is instituted early, and many cases may be prevented if proper care is exerted on the part of the attendants.

The prophylactic measures, which were suggested by Gibson as early as 1807, include attention to mother, nurse and infant.

1. The *mother*, in that if she has a leucorrhœal discharge, her vagina be antiseptically treated before and during labor.

2. The *nurse*, in keeping her clothes, her hands and all linen clean.

3. The *infant*, in cleansing the eyes as soon as the head is born.

Crede, of Leipsic, recommends instillations of 2 per cent. solution of nitrate of silver into the infant's eyes, and his reports of cases show excellent results.

Kaltenbach advises the use of bichloride of mercury, douching of the vagina and washing the babe's eyes with distilled water.

Some use dilute chlorine water, while others, again, prefer a 2 per cent. solution of carbolic acid. Most of the American hospitals use saturated solutions of boric acid, and the results are good.

If all our precautionary efforts are futile, and the swollen lids and profuse discharge appear, prompt measures are called for.

If one eye only is affected, we protect the sound eye, washing it first with a weak solution of bichloride of mercury (1 to 10,000) and hermetically seal and cover with a size bandage.

The principles of treatment of the affected eye are:

1. Application of cold compresses.

2. Cleanliness and antisepsis.

3. Use of astringents, treatment of complications and internal medication.

(1.) In the early stage, before the secretion of pus, we make continuous applications of cold by means of compresses of lint laid on ice and then placed on the eye. This, continued for a half hour at a time, usually relieves the pain and hyperæmia.

(2.) Thorough irrigation of the conjunctival sac with tepid boric acid solution and bichloride of mercury (1 to 8000),

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alternately, thus combining the astringency of the boric acid with the antisepsis of the bichloride. Weak chlorine water is preferred by some ophthalmists. Wash out all the pus, not wiping it off, but by flooding the conjunctival sac with these solutions until the solutions return clear. Repeat this every hour.

(3.) Local applications of nitrate of silver solution (gr. v-x., oz.j) to the everted lids which have been cleansed of the purulent secretions, never using the silver solution, however, until there is free secretion of pus. Repeat these applications once a day. In rare cases it is necessary to use the mitigated stick, but always have sodium chloride solution at hand to neutralize the excess of the silver solution. I have tried 1 per cent. solutions of argonin, a silver proteid combination, in a few cases of conjunctivitis, with good results, but the use of the drug has been too limited to present any data at this time. I believe it will be useful in these cases.

If the œdematous lids press on the cornea and the pressure renders the cornea hazy, cut the external canthi to relieve the pressure. When corneal ulcers form, hot applications are called for, and atropine solution (gr. iv., oz.j) if ulcer is central, or eserine (gr. $\frac{1}{4}$ to $\frac{1}{2}$, oz.j) if the ulcer is marginal, and if there is no iritis or ciliary involvement.

If anterior synechia or anterior staphyloma forms, operative interference must be resorted to in order to free the iris. When a dense leucoma covers the pupillary space, an iridectomy, or an iridotomy, will remedy the defect by furnishing a new pupil.

In conjunction with the local measures already referred to, our homœopathic remedies render us good service in these cases.

In the early stage we must think of aconite, belladonna, gelseminum, and in the latter stages, allium cepa, apis mellifica, arsenicum album, *argentum nitricum*, pulsatilla, hepar sulphuris calcareum, mercurius solubilis, euphrasia.

Ophthalmia neonatorum, which seems so simple in its incipiency, but which we note may be followed by such dire results, demands our most careful treatment. The proportion of the

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blind in our asylums who have lost their sight as the result of purulent inflammations of the eye in infancy is so large that the efforts at securing legislation to compel the reporting of all inflamed eyes in the new-born seems to be warranted. I feel that while our Pennsylvania State Board of Health is rather too extreme, in the statements in their circular on "The Prevention of Blindness," in saying that "No one should become blind from this disease," these statements will only have the tendency of making us more careful in our work.

The disease is important not only to the ophthalmists, but to the obstetrician and general practitioner as well, for the latter will save many a babe's eyesight, if the leucorrhœa of his pregnant patient is carefully treated before labor, and antiseptic douches are used during labor, and especially if care is exerted in cleansing the infant's eyes immediately after delivery.

Discussion.

Bushrod W. James, M.D.: There is one remedy not mentioned in the paper just read, which I have found good in my practice in most inflammatory affections of the eye, especially where there is great mucous secretion, and that is calendula, internally administered. When there is a great deal of œdema I dust the eye with boric acid, and place upon the eye small pledgets of cotton to keep the boric acid there as much as possible, so that when the eye is opened more or less of the boric acid gets into the eye and becomes dissolved by the secretions. It is an antiseptic and a disinfectant. These cases must be taken in hand promptly and watched carefully; the secretions must be removed from beneath the lids, otherwise, if you lose a case, you feel as though it had occurred through your neglect. I cannot say that I have ever lost a case entirely where I have kept up constant disinfection, as mentioned.

George W. Smith, M.D.: Dr. Schantz, in speaking of the homœopathic remedies in his paper, left out two which I found to be of importance in my practice; one is rhus, and the other is the iodide of arsenic. I have had good results from both.

William H. Bigler, M.D.: The necessity for correct diagnosis becomes important in this disease as it has some

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bearing upon the vigorousness of the treatment. We have frequently thought we had a case of ophthalmia neonatorum, whereas we had a catarrhal inflammation with great secretion, which responded to ordinary remedies without serious consequences. A great deal depends upon the time when the disease makes its appearance. A case of great inflammation of the eye which occurs ten days to two weeks after the birth of the child is no ophthalmia neonatorum at all, for this is a disease which is always the result of an infection, and makes its appearance shortly after birth, and these are the troublesome cases that you will have to deal with; and you may thank your stars if you are fortunate enough to manage to save the eyes, even with the greatest amount of care. It was formerly recommended to use a wash for the eye every ten or fifteen minutes during the whole day and night. I do not, however, think that this is absolutely necessary in all cases, for there are certain times when the condition of the eye would cause such a procedure to be attended with great danger, *e.g.*, when the cornea is affected. The violent efforts made by the child to close the eyes may lead to rupture of the ball, and you have a prolapse of the iris. As far as the treatment is concerned, cleanliness is paramount. I use iodide of arsenic frequently; but the only way you can possibly treat these cases successfully is to find out the constitution of the child and of the parents. I think constitutional remedies should always be given, for the local symptoms are always alike and their treatment does not vary.

D. C. Kline, M.D.: As we are living in an age of the prevention of disease, I wish to state that the best way to combat the disease under discussion is prophylaxis. My rule in obstetrics, in every case where there is a suspicious discharge, is to make use of vaginal douches of bichloride, even introducing the nozzle of the syringe into the cervix, if necessary, and to repeat these douches frequently, allowing the dilatation of the cervix to take place without the rupture of the bag of waters. Then we have only the vaginal canal, which we can treat with suitable remedies in our endeavors to prevent the occurrence of the disease.

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H. F. SCHANTZ, M.D.: The subject of the paper was suggested to me by a blind baby which was brought into the dispensary one afternoon; and, upon inquiring the cause of the infant's loss of sight, it struck me that the subject of ophthalmia neonatorum would be the best to present, for the reason that the trouble is not, as a rule, brought to the attention of an ophthalmologist at once, the majority of cases finding their way first to the general practitioner or obstetrician. I believe that if the suggestions in my paper were carried out, the statement that no one would become blind would practically become true. I refer to cases in the hands of general practitioners, and not those handled by midwives, neighbors, etc. I am glad that there has been a full and intelligent discussion given the paper, and thank you most heartily for your interest in it.

ORIFICIAL SURGERY WITH RELATION TO THE NASAL REFLEXES.

W. G. STEELE, M.D., PHILADELPHIA.

AMONG the affections which the physician is frequently called on to treat, I know of no more distressing one than severe headache.

Having been successful in curing a number of very severe cases of this malady by means easily applied, I thought possibly it might be of interest if I were to write something on this subject, explaining the method and giving a few illustrative cases. Some time ago, while making local applications in the treatment of hypertrophic rhinitis, I was gratified to observe that a particular case not only showed improvement in the nasal mucous membrane, but that a distressing headache, to which the patient had been subjected for several years, was greatly ameliorated, and finally was entirely cured. I then "looked the subject up," consulting most of the recent authorities, and having been so closely occupied in studying

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the reflexes from the lower orifices of the body, I was surprised to find the number of distressing complaints which had been traced to abnormalities inside the orifices of the nose, the cure of the patients following the correction of the nasal abnormalities, proving this to have been the cause of the reflex trouble itself.

I will enumerate some of the diseases so cured, as quoted by Bosworth, from Hack: "Gastralgia and dyspepsias, cardiac palpitation, tumefaction and redness, either temporary or permanent, of the skin of the nose, transitory and circumscribed œdemas, salivation, neuralgia of the first two branches of the trigeminus, cephalalgia, migraine, scotoma, ciliary neuralgia, photophobia, vertigo, agoraphobia and exophthalmic goitre, Hack asserting that all these were due to various forms of intranasal disease, the larger portion being due to hypertrophy or chronic hyperæmia."

Further quotations mention "complete aphonia, asthma, chorea, epilepsy and even nocturnal enuresis, and Dr. North says he has yet to see a case of neurasthenia in which there is not some catarrhal trouble."

Remember, gentlemen, the authorities quoted are not "orificial cranks," Dr. Bosworth going even so far as to state that "if we attempt to explain these various reflexes we find ourselves compelled to adopt rather vague and indefinite theories."

I believe the explanation to be easy if we consider that in these abnormalities there is a continuous pressure and irritation of terminal nerve filaments, the nasal membranes being so richly supplied by the olfactory and numerous branches of the trifacial nerve; and hyperæmia and hypertrophy must increase the pressure on these nerves directly, and the effects of nerve pressure are so pronounced that they manifest themselves with constantly recurring paroxysms, growing in intensity with each recurrence until finally, if long enough continued, the whole system is drawn into the vortex.

In another paper I have cited the example of a single hair of the head being put on a strain by a small weight, and, if continued long enough, the frightful consequences are infinitely out of proportion to the exciting cause. The strong man San-

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dow found it utterly impossible to bear the constant dropping of water in the palm of the hand from a height of two or three feet; after a half-pint had fallen in this manner drop by drop his sufferings became so intense that he was obliged to abandon the contest and lose a large forfeit.

But even should the theory of the causation be unsatisfactory, our patients are more concerned with results than with theories, no matter how beautiful, and I believe we all agree that nerve pressure is capable of producing pain, and that removal of nerve pressure will relieve pain, and this brings us to the consideration of how best to remove the pressure.

In this work a good light is essential; I use a McKenzie condenser and head mirror, with a self-retaining nasal speculum, preferring Goodwillies' with the central prong removed.

Patient in comfortable position, head steadied by suitable rest, introduce speculum and examine; usually the nasal membrane is found to be red, congested and hypertrophied; by making an application of a 4 to 10 per cent. solution of cocaine, the hyperæmia is greatly reduced, enabling us to examine further up the fossa, and reapplying the cocaine to the presenting portions, we are soon enabled to obtain a view of the entire cavity, unless prevented by malformation of septum or turbinated bones, which will require other treatment from that which I propose to explain; then heat the tip of a wire applicator to a red heat and dip it into chromic acid which has been triturated to the consistence of a coarse powder. A drop of the chromic acid will thus be fused on the end of the applicator; apply this to the portion of the membranes which seems most hypertrophied; this application is generally painless, but when the effect of the cocaine diminishes, violent sneezing sometimes results, and in some cases pain is experienced, which may be relieved by re-applying cocaine. Often have patients remarked that a treatment will induce a headache similar to that from which they have suffered, and I generally anticipate this by telling them that it may do this, and pointing out to them that if it does, it furnishes unfailing evidence that at last the cause of their trouble has been reached. These induced headaches sometimes last from a couple of hours to a day, according to

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the amount of irritation produced by the treatment; the great majority of patients, however, do not experience these unpleasant sequelæ.

This treatment may be repeated in from five to seven days, according to the subsidence of the irritation; sometimes one treatment, more often several, will be required to give complete relief from headaches which have existed for long periods of time.

Another method, which I often use, is, after making the cocaine application, to form a swab on the end of a probe, saturate this in compound tincture of benzoin and apply over the whole of the hypertrophic membrane covering the turbinated bones; it is not desirable to apply either of these substances to the septum. I frequently make the benzoin application without the previous cocaine application; the pain, while sharp, subsides in a few seconds.

Eye-strain is doubtless the cause of many severe headaches, and should always be remembered, but I find many cases which apparently are due to eye-strain, but which glasses fail to relieve, and these examples are particularly apt to be very amenable to this method of cure.

I select the following cases from my note books, in order to show the diverse classes of headaches which are cured by this method of treatment:

Case I.—Miss C.; age 24. About fifteen years ago she experienced a fall backward, striking the back of her head on a stove, after which periodical headaches began, and continued up to five years ago, when she was struck by a falling ironing-board also on the back of the head; this was followed by an attack of congestion of the brain, for which she was under treatment for about three months. Her headaches became greatly aggravated; she then had recourse to glasses under the prescription of an oculist, which gave her some relief. The case came under my care several years ago. I diagnosed chronic hyperæmia of the brain; my treatment was continued for several months without affording any pronounced relief; at this time these headaches were in the occipital region, the pains extending down toward the shoulders, accompanied by a sharp pressive pain as though

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something were being pressed upon the brain. A characteristic position was with the head thrown far back, as in cerebro-spinal meningitis, but without the cephalic cry; motion of the jaws and stooping always aggravated this pain; she also had a sensation of a metal band extending across the supra-orbital region, as though it were screwed up very tightly. These attacks occurred about every week, continuing from one to three days, and were followed by a marked prostration, lasting about two days after each attack; she was obliged to remain in bed during these attacks. She afterwards entered one of the prominent hospitals of this city, and upon consultation of three physicians of this hospital it was diagnosticated as an old fracture with overlapping edges, and trephining was advised; to this she refused to consent, and left the hospital, and again came under my treatment. I now, with my more recently acquired experience in similar cases, directed my attention to the nasal orifices. I found the membranes hyperæmic and hypertrophied, with the margin of the middle turbinated butted squarely against the septum. I treated this case with compound tincture of benzoin without the cocaine application, and with a single treatment, which was followed by a severe headache of the usual type, lasting one day; the benefit experienced was almost beyond belief. This application was made several months ago, since which time she has had almost complete immunity from the headaches and concomitant symptoms, her vision has greatly improved, and the sensation of the band over the eyes has disappeared. When it is remembered that these headaches had occurred regularly for five years, the period of exemption never being over two weeks, the gratifying result of this treatment will be appreciated.

The strong resemblance of this case to that of the celebrated singer, Madame Klafsky, who died recently after an operation of trephining for agonizing headaches following an injury to the occiput, produced by contact with heavy falling scenery a number of years ago, afterwards being struck near the same place by a falling board, will not be overlooked; her symptoms were very similar to those which characterized the above case. The operation of trephining in that case showed no pathologi-

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cal condition of the brain at all, but resulted in death. Medical reports now state that the cause of these profound effects was some trifling condition unmentioned, which could have been easily corrected had its importance been recognized.

Case II.—Miss G.; a girl of 22; has suffered for many years with most aggravated headaches of a blinding character, and extending into the eyes and over the frontal region, and thence to and beyond the occiput. Her weight was greatly reduced, and she was obliged frequently to suspend her usual occupations, and, in fact, became a physical wreck; her mother said she spent a large part of her time in crying. She was referred to me by a brother physician for experimental treatment of the nasal cavities, in connection with my investigations, of which he was aware. I found marked hyperæmia of both nasal cavities, with a profuse semi-purulent discharge through the posterior nares. It was an aggravated case of hypertrophic rhinitis, with great swelling of the membrane covering the turbinated bones; this overgrown tissue was pressing against the septum. I made eight applications of the benzoin in this case at weekly intervals, with the result of great amelioration in the severity and occurrence of the headaches; her complexion was cleared up, her countenance bright and full of vivacity, in fact, her appearance was so changed, that she looked like a different person. I do not consider this case entirely cured, although I have not treated her for the past three months, as I desired to see what nature will do in these cases if properly directed and without subsequent interference. The physician who referred this case to me has seen her recently, while attending other members of her family. She reports entire relief of the headaches and as enjoying splendid health; and her appearance is that of a perfectly well and extremely bright young woman.

Case III.—Physician, age 54 years, who was affected in 1868 by a partial sunstroke; as he has been a personal friend of mine for many years I know perfectly the horrible sufferings which he endured from headaches recurring at frequent intervals, these headaches lasting usually from one to three days, affecting the eyesight, the frontal region and the occiput down to the base of the skull, sometimes on one side, sometimes on both. The whole

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materia medica was tried in this case, both homœopathic and old school, the gentleman being a graduate of the Jefferson Medical College of Philadelphia. These headaches were by far most violent and persistent on the right side, but usually began on the right and after one day passed to the left, and on the third day again returned to the right. They were frequently accompanied by scintillations of light and muscæ volitantes, by a sensation of a band around the cranium, and by a peculiar sensation of a pain resembling a dead weight at some particular point which was suddenly transferred to some other part of the cranium. It was impossible to believe in this case, from the sensations, that the brain itself was not seriously involved. In fact, some of these symptoms were unquestionably cephalic, there can be no doubt of that; but I now know, and he knows, that they were reflected from the nasal branches of the ophthalmic nerve through the Gasserian ganglion. There was no particular catarrhal trouble in this case.* As I was at the time interested in these nasal phenomena, one evening while I was visiting him I examined his nose, and found abnormalities to such a degree that I had him call at my office and made a careful investigation. I found that while the membrane covering the middle turbinated on the left side barely touched the septum, that on the right side had developed to such an extent as to be fairly jammed and flattened against the septum.

I treated this case with cocaine, followed by chromic acid on the right side alone first, which developed the most painful subsequent symptoms that I ever met following this line of treatment; the pain was so great that cocaine almost failed to relieve it, the irritation extending to the tonsils, starting a genuine tonsillitis. I attributed, however, a great part of this subsequent suffering to his having contracted a severe cold the day following the treatment. The result in this case was almost miraculous; for two years afterwards the headaches were exceedingly few and slight, and, as a curious circumstance, now always began on the *left* side. I made but two applica-

* A headache very similar to this afflicted the late General Upton, of the United States Army, and the tortures were so great that they drove to suicide this extremely able officer.

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tions of the chromic acid in this case, and the peculiar cephalic symptoms, that is, the genuine brain symptoms, have disappeared entirely, and the headaches are practically cured. As a marked concomitant, a very remarkable improvement in vision has occurred, and the intense eye-symptoms are almost entirely removed.

I would like to call particular attention to the fact that in this case there was nothing to guide the investigation into the nasal orifices, since local symptoms were entirely absent, but as the gentleman had exhausted every available means in over twenty years' trial at curing this distressing malady, I felt sure there must be a cause somewhere and "hunted for it."

I make it a rule now whenever I meet a case of recurring headache, instead of first examining the eyes, to first examine the nose, and I would strongly urge this course upon the profession, because I have seen many cases in which the trouble was attributed to eye-strain and other like affections as the primary source, when in fact these symptoms were purely secondary and disappeared "like magic," as soon as the true source of nerve irritation was found, and removed, inside the nasal orifice.

I have used in other cases the electric cautery and various other modes of treatment recommended by the different authors with whom I am acquainted, but from my own practical experience I prefer the use of chromic acid, or the compound tincture of benzoin.

In most cases very little secondary inflammation follows the use of chromic acid, as you know chromic acid is peculiar among caustics for the reason that it is self-limiting, the contact with organic membranes causing it to be decomposed so as to form an insoluble sesquioxide of chromium, which is deposited in the membrane itself.

I would like to urge most earnestly a further study of the phenomena which characterize the reflexes which have their origin in those parts of the body in which the skin is merged into mucous membrane, that is, the orifices of the body. No biologist who understands the mode of development of the living animal can fail to see that it is right here that a line of

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functional division takes place, in which the nerve filaments are bunched instead of being distributed, and that the action of the reflexes is backward toward the nerve centres from these lines of division.

It is not because they are orifices merely, but it is because these are the areas which mark the grand division of peripheral nerve distribution, and in which the terminal filaments of two entire sets of nerve organisms are banked up against each other, instead of coalescing or crossing over into the opposite territory. Make no mistake; this is the true keynote to the philosophy of orificial surgery.

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REPORT OF THE BUREAU OF OBSTETRICS.

Dropsy in Pregnancy, by Ella D. Goff, M.D.
A Case of Breech Presentation, with the Funis Wound Around the Leg Above the Knee, by W. S. Bigelow, M.D.
The Present Status of Puerperal Infection, by Theodore J. Gramm, M.D.
Anomalous Pregnancies, by Pearl Starr, M.D.

DROPSY IN PREGNANCY.

ELLA D. GOFF, M.D., ALLEGHENY.

PREGNANCY and the puerperium is a purely physiological condition, and when normal should never be classed as a disease. In the healthy, properly-developed body every organ has its place and function. These admit of change within a physiological sphere without disease being a necessary factor. When the seeds of disease exist in the organism, awaiting a favorable opportunity for development, that opportunity is frequently furnished by pregnancy, which may exert a disturbing influence in the organism, effecting local changes in the sexual apparatus, the quality and quantity of the blood, giving additional labor to the heart and kidneys, and derangement of the reflex nervous and digestive systems. In pregnancy it is most important that a thoroughly physiological condition of the central organ of circulation exists. If the patient has been subjected to frequent attacks of rheumatism earlier in life, lesions may have been produced which interfere with the proper performance of the heart-function, and which may give rise to grave complications. When the heart and kidneys fail in the performance of their action, disease is a natural result.

In the development of the *fœtus in utero*, the quantity of circulating fluid is much greater than in the non-pregnant state, and consequently the heart and kidneys are called upon to per-

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form a greater amount of labor; and when these organs are not in condition to control in a natural way the extra amount of fluid, dropsy develops in many cases. When a superabundance of uric acid is present in the circulating fluid, convulsions of a more or less serious character are looked for at or before the termination of gestation. When the kidneys are in a condition that permits of an excessive discharge of albumen, anasarcous dropsy to a greater or less extent is frequently seen. And when, in addition to a crippled condition of the kidneys, organic changes have occurred in the heart, general dropsy in the latter stage of pregnancy is almost necessarily a result. In twin pregnancies these influences are intensified, and the dropsy arising from such complications becomes serious, and in some instances at least to a great degree jeopardizes the life of both mother and children.

During the past season a woman of 34 years, of medium build, rather pale, light complexion, brown hair, and a subject of rheumatism from childhood, came under treatment. The previous year she had had a protracted febrile attack of rather mild type, which, not passing away promptly, left her in a feeble condition. The winter following she became pregnant, and was a subject of morning sickness during the entire pregnancy. The urine was loaded with albumen to a considerable degree, and by the middle of her term she was very pale and much swollen with dropsy. At this time she was ordered to the Jersey coast, with the thought that the sea atmosphere would prove beneficial; but this was not realized, as she became more swollen with dropsy and anæmic in appearance, the urinary secretion becoming more scant from day to day. Returning to her home the last half of the seventh month, her bloodless appearance, with the swollen condition of her body and limbs, the rapid and unsteady pulse, the greatly reduced urinary secretion, only four to six ounces being voided in the twenty-four hours, the continued vomiting of all nourishment placed in the stomach, with dry tongue, intense thirst, an absolute indisposition to take nourishment, and being confined to bed the entire time, gave cause for the gravest apprehension.

The list of articles constituting the ordinary sick diet had

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become exhausted; consequently it was thought that something more gross and substantial might be tolerated by the stomach, and as it was thought that the case could scarcely be made worse by diet, corned-beef and cabbage, pork and beans, and other gross articles of food were named for the consideration of the patient and friends, and promptly tried. They proved to be almost the first elements that were not rejected by the stomach, and the seemingly reactionary influence began to show itself in the reddening of the lips and tinge of color in the face. The pulse became steadier and fuller, and the secretion of urine somewhat increased, but still of mahogany color. This condition lasted for a few days, when the throes of labor began to be felt. For two days desultory pains were felt at irregular intervals. On the 3d of August, at 5 P.M., pains finally became regular and labor slowly progressed, and lasted until 12.45 P.M. on the 4th of August.

A twin pregnancy had been suspected, which proved to be correct. Labor being protracted and her strength failing, it was thought proper to use the forceps with the first child. Almost an hour and forty minutes elapsed before the birth of the second child, and an hour and a quarter before the expulsion of the placentas, at which time a considerable amount of blood was lost. The children were female and male, and had separate placentas. The first placenta being detached and not coming away promptly, accounted for the hæmorrhage. The children were stillborn. The first one presented evidences of having been dead some hours, with blackened cord and discolored abdomen. The second one had evidently died later, as there was no evidence of decomposition save the distention of the abdomen. After the staying of the hæmorrhage and being allowed to drink freely, the mother presented evidences of reaction which proved to be permanent.

Notwithstanding the difficulties and unfavorable symptoms the breasts filled and lactiferous secretion was established at the regular time, which was allowed to continue for a few days, but was gotten rid of without difficulty. The urinary secretion was slow in its increase of quantity, but showed signs of improvement which were more marked as the secretion of milk

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disappeared, and became quite large by the tenth day after labor, amounting to more than a gallon a day, with a corresponding decrease in the size of body and limbs, and increase of appetite and capacity for nourishment.

We would here state that the gross articles of living had to cease from the time of labor, and the utmost care and consideration in the selection of articles of diet were necessary. The excessive flow of urine began to lessen during the third week after delivery. At the end of the fifth week the urinary secretion had receded to its normal quantity, at which time rheumatic symptoms were re-established in the left chest and pericardial region, with very considerable pain at times, but this was controlled by the proper homœopathic remedies.

On her return from the coast china, arsenicum, benzoic acid, arsenicum hydrogenisatum were the remedies made use of prior to the time of labor. During labor secale and pulsatilla were used. Since labor arsenicum hydrogenisatum, ranunculus bulb., bryonia, phos., squilla, spigelia and digitalis have been the principal remedies.

The rheumatism is gradually disappearing, the appetite remains good, digestion prompt, sleep refreshing, mind clear, with gradual return of strength.

A CASE OF BREECH PRESENTATION WITH THE FUNIS WOUND AROUND THE LEG ABOVE THE KNEE.

W. S. BIGELOW, M.D., PHILIPSBURG.

LATE in the evening of the 28th of May, 1895, I was called by telephone to see a patient some three miles from my office. The evening was pleasant, and as a friend was present at the time of the call, I asked him to go along. We soon reached the place, and I went in to see my patient. Much to my surprise I found the case was a confinement, and a difficult one at that, and I was not prepared. After learning what the case

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was I sent my friend for my obstetrical satchel, and I went in to see what I could do to relieve the woman.

She was a French girl, æt. 18, large and muscular. She had not expected to call a physician, thinking she could get on without such aid, but having been in labor all day, and having made no progress, she was persuaded by the older women who were with her to call a doctor.

On examination, per vaginam, I found it was a breech presentation, and the parts so large that they could not be forced down into the pelvic strait. With each uterine contraction the meconium flowed freely from the vagina. The pains were almost constant, and the patient seemed to be suffering very severely. I could not discover that the fœtus made any descent into the pelvic strait, though the contractions were severe. The cervix was widely dilated, and everything seemed favorable except the size and position of the fœtus. The girl could understand a little English, but none of her attendants. So having explained to the patient as best I could what I wanted to do, I passed my hand into the womb, thinking I would turn the child and deliver in the first position. I passed my hand up between the thighs of the fœtus, and in so doing found that one leg was bound closely to the abdomen of the child. On closer examination I found the left leg had two folds of the cord tightly drawn around it above the knee. The womb was contracting most vigorously all the time. Passing the thumb under the cord on the leg, I pushed it over the knee and drew the leg out of the loop. Having carefully examined the head and decided that the child could be safely delivered feet first, I drew down the other foot, which was back of the head, and delivered at once a girl weighing eleven and a half pounds. The remainder of the case was normal in every way. On the third day, as I went into the house, I found the mother sitting up, and, as she said, she was well.

My reasons for presenting this case are the following:

I. It is the first and only case I have had in which the cord was wound around any one of the limbs. I have had many cases where it was about the neck in so many folds as to shorten the cord to such an extent as to seriously interfere with the

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progress and ease of the labor. Some have required great care to prevent rupture of the cord or strangulation of the child. Neither have I found much in the text-books with reference to this complication. Guernsey makes no mention of it, neither does Leavitt. Cazeaux and Tarnier say, on page 835, on the subject of "Accidental Shortening of the Cord": "The turns of the cord around some part of the body are quite common occurrences. Mayer states, in his inaugural thesis, that out of 3587 deliveries which took place between 1828 and 1841, these were present in 685 cases. Five hundred and sixty-four of the children were born alive, seventy-two were in a state of asphyxia, but recovered under proper treatment, and forty-nine were dead. In eighteen of the latter cases, however, the death could not be regarded as due to the wrapping of the cord."

II. This cord was not of unusual length. The authors last mentioned state, on page 834, Article II., "Of Shortness of the Cord," "The cord may be very short naturally, and, as elsewhere stated, it has been known not to exceed four or five inches in length, but such cases are very rare; most generally its brevity is accidental, that is, results from the numerous turns made around the body, limbs, or the neck of the child. The formation of these circular loops are favored by an unusual length of the cord."

III. That notwithstanding the evacuation of the child's bowels, in utero, there was no sepsis following. It is true that the membranes enveloped the fœtus, and that they were intact except in the lower portion, consequently but a slight portion of the endometrium could be affected by this accident. But when we consider how little foreign material it sometimes requires to set up very serious and destructive changes, it seems strange that no trouble followed; yet I have never seen any trouble in the few cases I have observed.

IV. In Vol. I., of Cazeaux and Tarnier, page 400, second paragraph, it says: "In breech presentations the introduction of the finger into the anus will detect the resistance and contractile power on the part of the sphincter if the child be living, which will be absent if the child be dead." In this case all contractility of the sphincter was absent, yet the fœtus was easily re-

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suscitated after delivery by the introduction of the finger into the anus. This success I have attributed to the very prompt manner in which the child was delivered, for it seems plain to me that the contraction of the cord had already produced partial asphyxia, and if it had been allowed to continue, efforts at respiration would have followed, and the lungs filled with amniotic fluid, and death would have been inevitable.

THE PRESENT STATUS OF PUERPERAL INFECTION.

THEODORE J. GRAMM, M.D., PHILADELPHIA.

"Every puerpera represents a wounded one."—*Cruveilhier.*

THAT there are still physicians in both schools who do not practice the antiseptic method in obstetrics, and are not convinced of the necessity for the precaution which that method includes, is a fact which sometimes becomes conspicuous. To the majority of us most of the facts which I shall present are familiar, and have served as unerring indices along the difficult road which the obstetrician is sometimes compelled to travel. To others these facts may not have appeared to exhibit the necessary credentials for acceptance, because some correlated circumstances had not yet been elucidated, and therefore these facts have been looked upon as fallacious guides in practice. There may be some physicians who possibly have not considered the available material in favor of the antiseptic method in a logical sequence, nor in their relation to analogous facts in other fields of medicine. I have therefore thought that it might be profitable to review the facts upon which rest the present views concerning puerperal infection as held by the majority of obstetricians.

It is interesting to observe in the manners and customs of primitive peoples* that among them and among their types yet remaining are found many practices which appear to have a

* Engelmannn, *Labor Among Primitive Peoples*, St. Louis, 1884.

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direct reference, not only to the parturient but also to the puerperal period, and which evince a dread of something more than is involved in the parturient act. That this dread of an unfavorable puerperal period was well founded is evidenced by the fact that many women died of what we would now call puerperal infection. In later times we find not only that many women have died from puerperal fever, but that in fact there have been most frightful so-called epidemics* which have desolated entire communities and transformed the place of refuge, the lying-in hospitals, into a charnel house. While physicians for centuries have been appalled at the frightful ravages of those diseases, and have made more or less persistent efforts to determine the cause, yet it is really only within the memory of the generation just passing away that anything like a satisfactory advance has been made in a knowledge of puerperal diseases. I suppose we need not long be detained by the old views† of the ætiology of so-called puerperal fevers: the theory of retention of lochia and decomposition of placental remnants; of metastasis of milk; of recession of excretions, sweat, lochia and milk; the gastro-bilious theory; the phlogistic theory; the erysipelatous theory, which regarded puerperal fever as an internal erysipelas; the discussions of the localists and essentialists. In 1847, however, a new theory was proposed by Semmelweis‡ which has been more beneficial in its influence than any discovery in the ætiology of disease until that time. He believed that puerperal fevers, of which so many women died, were induced by cadaveric, and later he included other unknown poisons which were carried to the puerpera in the course of her delivery by the attendant. Concerning this theory history has repeated itself. It remained for a later generation to appreciate the import of this discovery, which marks an era in medicine. The circumstances of that discovery will never

* Meigs, *On the Nature, Signs and Treatment of Child-Bed Fevers*, Philadelphia, 1854, letter vii.

† Charpentier, *Cyclop. Obst. and Gyn.*, New York, 1887, vol. iv., p. 228; Winckel, *Obstetrics*, Philadelphia, 1890, p. 842; Eisenmann, *Die Kindbettfieber*, Erlangen, 1834.

‡ Winckel, *Münchener Med. Wochenschrift*, 1893, No. 46.

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lose their interest. Time will not now permit me to recite them in detail. For our present purpose it must suffice to say that, acting in conformity with the deductions from his observations, Semmelweis, at the Vienna Maternity, compelled those who attended or examined women in parturition to wash their hands in chlorine water or in a solution of chlorinated lime, and immediately the mortality fell from 11.4 per cent. to 1.27 per cent.

In America Professor Oliver Wendell Holmes directed his attention to this subject and published his well-known paper* on "Puerperal Fever as a Private Pestilence" in April, 1843. Holmes says he was led to consider this subject in consequence of a discussion following a report "of a physician who made an examination of the body of a patient who had died of puerperal fever, and who himself died in less than a week, apparently in consequence of a wound received at the examination, having attended several women in confinement in the meantime, all of whom, as it was alleged, were attacked with puerperal fever." Despite the masterly manner of its presentation and the overpowering conviction which his facts should have engendered, the essay did not make many converts. On the contrary, his views were opposed by Professors Hodge† and Meigs,‡ of this city, and a controversy ensued. Both in Germany and in America discussions of this nature were maintained for many years. The greatest eloquence was expended in favor of the non-contagious theory, whereas, on the other hand, an incontrovertible array of facts were presented in opposition.

In addition to the observation of Semmelweis which led to the formulation of his new doctrine, and in addition to the clearly recorded facts given by Holmes in his essay, many more incidents indicating the character of so-called puerperal fevers could be named which were observed with all the keenness of a recently awakened interest. The literature of forty years ago

* *Medical Essays*, Philadelphia, 1895, p. 105.

† Hodge, on the "Non-Contagious Character of Puerperal Fever," introductory lecture, Monday, October 11, 1852.

‡ *Loc. cit.*, Lecture VI.

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contains many instances, many of them independent observations which endeavored to sustain no particular theory, of physicians suffering from septic infection from cases of puerperal fever, and of physicians or attendants carrying septic infection to women and lighting up puerperal fever, and of epidemics which attended certain physicians or certain midwives, or raged in particular communities or institutions where the hygienic conditions were more or less above suspicion.

A case which excited much interest for many years, and one which served to illustrate the views of many who debated this subject, regardless of how diverse those views might be, was that of Dr. David Rutter, of this city, and later of Chicago. The experiences of this physician with puerperal fever have been oft repeated. To Professors Hodge and Meigs these experiences verified one view, and to Professor Holmes and others they verified the contrary view. The facts in brief are that Dr. Rutter had seventy cases of puerperal fever in less than a year, while neighboring physicians had very few cases or none at all. "Worn out with fatigue and wounded in spirit," he left the city for ten days. On returning to the city "he caused his head to be close shaved; he entered a warm bath, and washed himself clean; he procured a new wig, new clothes, new hat, new gloves and new boots. He did not touch anything he had worn, and took the precaution even to leave his pencil at home and his watch. He went to attend a lady in labor, who had a favorable parturition, yet was next day assailed by a horrible child-bed fever, of which she died. Dr. Rutter repeated his attempt at personal disinfection at a subsequent period, which was two years later, and with the same ill-success."* This case, which has figured so largely in discussions on puerperal fever, has been fully explained. Harris† states, on the authority of a contemporary, that Dr. Rutter was affected with ozœna, which greatly disfigured his nose in time, the primary infection in his case having occurred from a pustule upon his index finger.

Thus far have been presented some of the facts and inci-

* Meigs, *loc. cit.*, p. 105.

† *Harris's Amer. Jour. Med. Sci.*, Apr., 1875, p. 474, and *Playfair's Obstetrics*.

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dents related to puerperal fever in its early awakened interest in quite recent times. In this connection a later matter deserves attention. On December 6, 1883, a memorable discussion, as it has been aptly called, took place before the New York Academy of Medicine, in the course of which a number of the ablest obstetricians and gynæcologists took part. The discussion followed a paper by Dr. T. Gaillard Thomas on "The Prevention and Treatment of Puerperal Fever," in which he summarized the advanced views at that time, and named ten rules for the prophylaxis and treatment. The influence of this discussion was far-reaching and attracted attention to the new theory and treatment more effectually than any previous paper. The paper was ably opposed by Dr. Fordyce Barker, who said: "All would agree that the paper was remarkable for its originality, in that some of its pathological doctrines and practice inculcated for the prevention and treatment of puerperal fever had never been taught in any work on obstetrics or by any writer of acknowledged repute."* Almost every shade of opinion was expressed. The discussion doubtless caused some surprise in Germany, for it was soon followed by a paper by Carl Lomer,† who was an assistant at Schröder's Clinic, wherein he presented "the facts which have thus far been offered as such regarding the relationship which exists between micro-organisms and puerperal fever." The paper throughout is rather in the nature of an inquiry in which facts and not arguments are presented. The most important conclusions reached from these inquiries are briefly that: 1. Of all micro-organisms found in puerperal fever the chain-like micrococcus is of the greatest importance. 2. When found in the exudations of any case of puerperal fever, they have also been found in the deeper organs. 3. They have been found in erysipelas, scarlet fever, diphtheria and puerperal fever, and in each possess the same form and show the same disposition towards fertilizing fluids and coloring-matters. 4. Although different varieties may exist in these diseases, we have as yet

* *Amer. Jour. of Obstetrics*, 1884, p. 288.

† "Our Present Knowledge of the Relations Between Micro-Organisms and Puerperal Fever," *Amer. Jour. of Obstetrics*, July, 1884, p. 673.

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no positive proof of the same. 7. Chain-like micrococci have also been found in infected wounds and in the blood of pyæmia. 8. The pathological and anatomical investigations in these diseases show that they possess similar micro-organisms. 9. Besides the chain-like micro-organisms, others may be present in puerperal fever (*i.e.*, mixed infection). 13. In some cases no micro-organisms have been found, but this does not prove that they do not exist.

In the light of these conclusions, many of which are drawn from most elaborate investigations, what can be said of the *cause* of so-called puerperal fever? We are compelled to turn from such views as entirely inadequate, as are those of Fordyce Barker,* that, "In private practice it is generally due to some occult, possibly atmospheric, epidemic influence; in hospital patients, nosocomial malaria, often associated with septic poisoning;" and those of Meigs, that the cause is an accident or a visitation of Providence rather than of contagion; and from the opinion of Hodge that the dignity of the profession is compromised when acknowledging that the physician can ever become "a minister of evil; that you can ever convey in any possible manner a horrible virus, so destructive in its effects and so mysterious in its operations as that attributed to puerperal fever."

Denman† was probably the first to contend that midwives and nurses conveyed the disease from one patient to another, and he cautioned against the impropriety of those who are engaged in the practice of midwifery attending patients in fevers and other dangerous diseases. Instances verifying the truth of this induced physicians to abstain from practice for a time if puerperal fever appeared among their patients.

Mayerhofer‡ was the first to discover micro-organisms in purulent fluids from the pleural and peritoneal cavities of puerperal patients, and in 1865 he determined that the lochia of infected women were in character putrid, and discovered

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* *Amer. Jour. of Obstetrics*, 1884, p. 292.

† *Midwifery*, Brattleborough, 1807, p. 429.

‡ Quoted by Lomer, *Monatsschr. f. Geb.*, vol. xxv., 1869, p. 129.

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motile vibrios, which, according to him, were the cause of the putridity.

Rindfleisch* followed by a description of vibrios in suppurative carditis. Many others have been engaged in the same line of observations—Recklinghausen, Waldeyer, Klebs, Orth, Heiberg, Landaŭ, Spillman, Doléres.

Pasteur in 1879 instituted most valuable researches, which are well known, as a result of which he established the presence and action of micro-organisms, and by his culture-methods and inoculation of animals was able to demonstrate conclusively the rôle played by micro-organisms in the ætiology of infective diseases. He likewise for the first cultivated the streptococcus from the organs of women who had died of puerperal fever, and many others† thereafter verified his observations.

Then it was shown by Brieger‡ that the staphylococcus might cause fatal puerperal infection, though, as a rule, only the milder cases are induced by this coccus. These observations were likewise verified by many investigators.

Döderlein reports§ three cases of puerperal infection which resulted from a purulent ophthalmia in one of the patients, and terminated fatally in one instance. In these cases the infecting micro-organisms were proved to be streptococcus pyogenes and staphylococcus pyogenes aureus.

In another work Döderlein‖ concludes, after quoting Doléres, Lomer, Czerniéwski, Widal and Bumm that, according to all existing investigations, a disproportionately greater significance may be attributed to the streptococcus pyogenes for the origination of puerperal fever than to the staphylococcus.

Gonococci have been found to have caused nine mild cases of puerperal disease by Kronig.¶ He reports that while none of the cases terminated fatally, yet there was an elevation of temperature in some cases to 104.3° F. The lochial discharge

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* *Gewebslehre*, ii., 10 Aufl., p. 204.

† For literature, see Lomer, *loc. cit.*

‡ Williams, *Amer. Jr. Med. Sci.*, July, 1893, p. 57.

§ *Centralblatt für Gynäkologie*, 1891, No. 51, p. 1038.

‖ *Das Scheidensekret*, Leipzig, 1892, p. 55.

¶ *Centralblatt für Gynäkologie*, 1893, No. 8, p. 157.

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in all the cases was increased, pus-like, not offensive, and frequently already on the fourth day was purely purulent. Seven of the nine cases were discharged on the fifteenth day, but still had a markedly purulent discharge, and there was pronounced subinvolution. In two of the cases there was pelveo-peritonitic and parametric exudates, and the conclusion is reached that the extension of the inflammation from the endometrium through the tubes to the peritoneal cavity leads to the well-known gonorrhœal diseases of the adnexa.

The colon bacillus has been demonstrated to play an extended rôle in the ætiology of disease. Eisenhart* describes a fatal case of late puerperal infection in which the bacterium coli commune was the infecting germ, and which the pathological lesions found post-mortem proved did not enter the tissues through an intestinal lesion, but by way of the uterus. He likewise quotes Von Franque, who found this bacterium in pure culture in one case, and also mentions Schwarz, who in a case of puerperal peritonitis found, besides a few streptococci, the bacterium coli commune in great numbers.

In addition to these micro-organisms which have been demonstrated in certain cases of puerperal infection, many more might be named. Indeed, Ernst† has expressed the view that in this relation many micro-organisms demand attention, namely, such as may infect wounds, regardless of whether they have been found in the puerpera or not, since the wound infection resulting in pyæmia and septicæmia is the same as may result in so-called puerperal fever. From the above bacteriological observations we see that just as Welch‡ has said, so likewise is verified the statement of Spiegelberg,§ "that puerperal fevers are only wound infections, only pyæmia or septicæmia, that therefore everything which is applicable to the wounded is likewise so for puerpera—an analogy which Simpson first endeavored to establish."

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* *Archiv. für Gynäkologie*, Bd. xlvii., Heft 2.

† *Amer. Syst. Obs.*, Philadelphia, 1889, vol. ii., p. 401.

‡ "Conditions Underlying the Infection of Wounds," *Am. Jr. Med. Sci.*, November, 1891, p. 439.

§ "Ueber das Wesen des Puerperalfiebers," *Volkman's Klin. Vortrage*, No. 3.

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Now, what are some of the peculiarities of the puerperal wound and of the puerperal condition in general which favor infection? The pregnant and puerperal woman is in a peculiarly susceptible condition for the development of septic processes. I need hardly review in detail the well-known anæmic and hydræmic condition of every gravida which is so readily augmented by every cause of malnutrition and defective hygiene, the elements of nervous shock and physical prostration which attend every delivery, in addition to the hæmorrhage, which is usually so great as to affect the appearance and condition of the woman. There are circumstances here which have been experimentally demonstrated to favor bacterial infection. Welch* says: "Gärtner has recently brought forward evidence derived from experiments on animals showing that general anæmia and hydræmia render easier the infection with small quantities of the staphylococcus aureus, and Ribbert has demonstrated that the presence of toxic products of the same micro-organism in the circulating blood favors the development of foci of suppuration, a fact which evidently bears upon the pathology of pyæmia, etc." The presence of wounds and their condition in every puerpera favor infection. Wounds exist far more frequently than any may suppose who do not habitually look for them after delivery. The placental site, formerly compared to an amputation stump, with its multiple venous lesions, its close proximity to the peritoneal cavity, its numerous lymph channels, the sometimes imperfectly contracted condition of the muscular substance of the uterus, furnish conditions which must be considered in regard to infection. The same holds good for wounds in the cervix, either such as are distinctly recognizable as lacerations or only such as later leave no trace whatever in tissues whose lymphatics lead directly to those of the pelvis; the injured pelvic tissue whose substance is subjected to great pressure and displacement and whose vascular supply is thereby greatly disturbed; the wounds in the vaginal walls in addition to those well known to occur at the perinæum. About the vaginal outlet the wounds are *contused* and *lacerated* wounds which notably do not heal kindly, and which here, in addition,

* *Loc. cit.*, p. 451.

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are subjected to all the dangers which arise from their situation partly on a cutaneous surface in a locality which is notably difficult to keep aseptic. The lochial discharge bathing these wounds furnishes not only a good culture medium, but likewise a pathway along the wounded genital canal which micro-organisms may travel, so that not only is there a pronounced interference with the integrity of the living tissue which is a predisposing cause of suppuration in case suitable micro-organisms gain entrance, but a culture medium is furnished for their reception and development until they have time to reach the tissues.

Let us look now to what this leads, or, I should rather say, to what this *led*, for I am not unmindful that the majority of obstetricians everywhere have adopted these views many years ago. As a preliminary, the old nomenclature, the old pathology must be abandoned. The old name, puerperal fever, finds no place now in designating the protean manifestations of puerperal infection, and in the same manner must a new pathology be adopted. Charpentier* succinctly expresses the views held by many writers a few years ago, when he says: "To entirely reject this term (puerperal fever) is to enter the road which leads directly to the localization of puerperal affections." Now, this is just what has taken place, and the situation is most concisely stated by Welch† when he says: "The manifold varieties of puerperal fever, which is now known to be a typical wound infection, may be caused by apparently the same streptococcus, producing a mild endometritis, a pelvic abscess, localized or general peritonitis, pyæmia, or the most virulent and rapidly fatal septicæmia." Logically, we should now consider some cases which illustrate the correctness of the views for which this paper contends. Such reports of necropsies can readily be found. A small series reported by Williams‡ happens to be at hand, wherein, following a lack of proper antiseptic precautions, infection took place. Several forms of infection are demonstrated, and by the methods of bacteriology

* *Loc. sit.*, p. 287. † Welch, *loc. sit.*, 464.

‡ Williams, *Trans. Gyn. and Obs. Soc. of Baltimore; Am. Jour. Obs.*, vol. xxxiii., p. 271.

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the infecting micro-organisms were isolated and identified. Another series of cases of puerperal infection is reported by Braxton Hicks,* wherein the probable source of infection is clearly suggested. On the other hand, a search through current literature and recent text-books will be rewarded by innumerable illustrations of the efficacy of the antiseptic method as applied to obstetrics. A single reference, doubtless readily available, as I have endeavored to make all my references, is all the present occasion will permit. Garrigues† reports a mortality of 4.4 per cent. during the five years preceding the adoption of the antiseptic method at the New York Maternity Hospital, while during the five years succeeding its adoption the mortality from all causes was 1.06 per cent., and from sepsis alone 0.27 per cent. During the last month before the change the total mortality was 20 per cent., of which 15.69 per cent. was from septic infection, while immediately after, in the first three months, 102 deliveries were effected without a single death. As a further result of the adoption of the antiseptic method, the much-dreaded epidemics of former times have entirely disappeared from maternity hospitals. Indeed, the anomaly is presented that the pauper and the outcast to-day has a far safer delivery than was and sometimes is now furnished by the best homes. Epidemics in private are rare indeed to-day.

The considerations thus far presented would seem to confirm the proposition that every puerpera presents the condition of a wounded one, and there are no manifest reasons why, therefore, the further proposition should not be adopted that everything which is applicable to one is equally so to the other.

In what shall the treatment consist? Manifestly in preventive measures, and these failing, in the use of means to combat the septic condition. Clinical experience notably demonstrates it to be far easier to prevent sepsis than to remove that condition. For the prevention of sepsis the indications are positive, the requisite means are clearly defined, the course of action is

* J. Braxton Hicks, *Trans. London Obstetrical Society; Am. Gyn. and Obst. Jour.*, vol. v., p. 320.

† Garrigues, *Am. System of Obst.*, Philadelphia, 1889, vol. ii., p. 339.

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not the subject of debate. The brilliant achievements of surgery have not been attained in consequence of any recently acquired skill which has been bestowed upon surgeons as a new attribute, for instance; but they result mainly, if not solely, because the antiseptic method *permitted* the exercise of that skill which surgeons already possessed. Of the curative means we cannot speak so positively. The views of physicians do not make even an approach to the same unanimity. I would like to enlarge upon that statement, but must forbear at present.

How do septic germs obtain access to the puerperal wounds? They are carried there by the hands of the accoucheur, by his instruments, by the hands of the nurse, by unsterilized vulvar pads, by unclean douche nozzles, by the family douche-bag, and in fact by every other existing means whereby a wound in general may be infected. This simple enumeration indicates what matters require attention in applying the antiseptic method, and it is not my intention, therefore, to consider in detail the various means at our disposal in order to obtain asepsis.

Now what shall we say of physicians who have practiced medicine for a great number of years and claim they have never had a case of puerperal infection? I would not for an instant detract from the value of the experience and skill engendered by long years of practice, but such claims are based upon negative observations, which you must admit are outweighed by a single positive observation. One single authentic case of puerperal infection following exposure by any of the multitudinous means whereby it may be induced by reason of failure to observe antiseptic precautions, far outweighs numerous instances where infection did not follow an apparent exposure where antiseptic precautions were not taken. Besides, the memory is a most untrustworthy witness in such considerations, and is overclouded and unreliable in the presence of a conviction that a given event may not happen. The fact that in every instance, or in many instances, death from septicæmia did not result where there were no precautions taken against it does not militate against the fact that under suitable conditions sepsis follows exposure.

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In conclusion, I have but to remark that puerperal infection is a preventable condition, and the success in general surgery, the success in large maternities and the complete obliteration of epidemics which have been effected by the adoption of the antiseptic method, clearly indicate the necessity for its adoption in general practice.

DISCUSSION.

JOSEPH C. GUERNSEY, M.D.: I think if we had fewer papers and more discussions it would be better for the interests of this Society. I particularly noticed yesterday, in the Bureau of Clinical Medicine, that paper after paper was read without discussion; and what I considered the best paper of all (that by our worthy chairman) was suppressed by his self-sacrifice.

Now, in this paper of Dr. Gramm's there is food for discussion for three days. He decides nothing, but leaves it open for us to discuss and decide. We have been urged to use antiseptic methods in puerperal infection. I think in the majority of cases asepsis is amply sufficient. I believe that douching with bichloride of mercury, carbolic acid, etc., is injurious. I do not do it. Asepsis is all that is necessary, because nature protects her own; she will furnish all the rest. To keep the patient clean is all that is necessary.

J. N. MITCHELL, M.D.: I did not propose to get on my feet during this discussion, but what Dr. Guernsey has said forces me to do so.

As an obstetrician, I see no advantage in discussing and placing in opposition to one another asepsis and antisepsis, since both are useful and both have their appropriate places: one as an agent to prevent the growth of micro-organisms, the other to kill them when in full growth.

The idea in the minds of many homœopathists is that they must not use any drugs to prevent disease, and by this mistaken idea they permit disease to gain a foothold.

I wish to say, furthermore, that I do not consider that this subject has anything to do with homœopathy, or any other pathy, but belongs to what should be included in all schools of medicine—that is, the prevention of disease.

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As I understand homœopathy, it is necessary to have some symptoms, some disease, before you can prescribe for your patient. Any other method of prescribing would be denounced by Dr. Guernsey as not under our law, whereas the subject we have under discussion is how to prevent our patient from having any symptoms or disease that will make it necessary to call upon Dr. Guernsey, or doctor anybody else, to prescribe any medicine at all.

When we make use of an antiseptic wash on patient, nurse or doctor, and upon all things coming in contact with our patient, our effort is to kill all germs that may exist; we do so to bring about asepsis.

Now, if this asepsis could be brought about without drugs, well and good. We can boil our instruments, but we cannot boil our patient nor our hands. Hence, in my opinion, it is necessary to use means which will destroy any germ, and will produce surgical cleanliness.

Besides this excess of cleanliness, avoid too frequent vaginal examinations, and exercise yourselves in the habit of making abnormal explorations for the purpose of diagnosing positions; and should it be necessary to pass the hand into the vagina or uterus, remember the added risk to the patient, not by injuring and bruising the parts, and so producing inflammations, as was once supposed, but by introducing germs which, finding a place to grow, will grow; and, remembering this fact, use conscientiously all the means placed in your power to prevent such an occurrence.

G. Maxwell Christine, M.D.: I heartily commend the author of the paper for its comprehensiveness, and trust he will distribute copies among the profession for their enlightenment.

Dr. Gramm is justified in saying that in the majority of cases ordinary cleanliness is all-sufficient, that the greater number of cases surrounded by unclean conditions are dangerous, and that for this reason he does not trust to methods of ordinary cleanliness. If the accoucheur could be certain of his cases he would need to observe no other than ordinary methods of cleanliness, but he could not be so certain. For the reason, therefore, that there are cases, if only two or three in a hun-

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dred, which may become septic, he must pursue such a plan for the protection of the few as will also include the many.

He cannot tell beforehand what cases will and what cases will not become septic, and if he wishes to avoid danger he must comprehend all of his cases under one method for disease-prevention. The sooner a confinement case is considered a surgical case the better it will be for women. From the surgeon we should take our lessons. He permits no operative case to be an exception to his methods of cleanliness, and he does not regard ordinary cleanliness a sufficient asepsis, but makes every possible effort to secure surgical cleanliness. The surgeon recognizes many sources of sepsis, the patient, the nurse, the surgeon, his assistants, the surroundings, etc. He omits no effort to enforce surgical cleanliness on the part of every one about the operation, and to have the whole environment in perfect agreement with this principle. So it should be with a case of confinement. There should be a rule, from which, if possible, there should be no departure. Of course, the surgeon is usually so situated with respect to his cases that he can observe a routine practice, while the accoucheur may often have little opportunity for so doing.

Whenever possible, however, strict attention should be paid to getting the puerperal woman in a surgically clean condition, and to have the attendants, the dressings, etc., made surgically clean. For this purpose, something can be done in every case —the methods being more or less elaborate as circumstances will permit. The accoucheur ought to be provided with clean, white, duck trousers, and white coat. He should prepare his hands and arms, preferably by means of the permanganate and oxalic acid method. The patient should have been washed about the thighs, buttock, genitals, etc., with soap and water, and the rectum cleansed by soap enemata. Some question the advisability of using vaginal douches, believing that they clear away certain valuable bacteria.

We have just heard a paper on "Ophthalmia Neonatorum," which was a strong plea for antiseptic douchings of the vagina prior to and during labor. For my part, I am unsettled in my opinion as to whether we should adopt an inflexible rule and

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douche all cases. I have sometimes regretted the procedure, but oftenest have regretted my failure to observe it. The safest plan is to treat all obstetric cases as though septic, it will harm none, and may save a great deal of misery. In maternities, the good effects of antisepsis is very apparent. In the ordinary house obstetrics, the difficulties attendant upon securing proper antisepsis are often insurmountable; but if we desire good results, we should pin our faith to antisepsis, and be ever diligent in its observance.

THEODORE J. GRAMM, M.D.: I have read to you from my paper some facts which are capable of demonstration, and in presenting them I ask you what are you going to do with them? What conclusion shall we arrive at? The time is coming when the obstetrician may be exposed to a suit for malpractice unless greater care is taken to prevent infection during the puerperium. I find that some men believe in the use of antisepsis, others do not; and the fact that it sometimes appears to be an unsettled question has suggested my presenting the subject to you. The deduction from the facts presented is that preventive measures in some form *must* be used in obstetric practice.

ANOMALOUS PREGNANCIES.

PEARL STARR, M.D., BELLEVUE.

IN all ages Nature has produced anomalies in the mineral and vegetable kingdoms as well as in the animal.

Could we understand her better we might be able to discover the reasons for these deviations. The *Obstetrical Journal* for the past year records the case of a woman, 59 years old, giving birth to a healthy male child and nursing the same.

The writer has under her care a patient who, with her twin sister, was born when her mother was 50 years old.

Another patient, when she was 47 years old, was being treated by an old-school physician for the climacteric, when

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she discovered she was pregnant; eight years later she was regularly changing.

The following case came under observation in May:

Mrs. E.; age, 52; tall and slender; brown hair and gray eyes; had never changed; regular; not oftener than three or four months; the waste was small and had little color to it. She had always had ordinary good health; was married at 20; about one year later had a miscarriage, from which she recovered without any bad effects.

Nearly twelve years afterwards she gave birth to a daughter, weighing about eight pounds. The labor was normal. Has not been pregnant since. Some two years ago she bloated; the abdomen was considerably enlarged; she had a flooding of water; after that the bloating disappeared; but health had been very poor, she felt miserable ever since.

In May she presented herself for examination, for what she supposed was a tumor. After removing the outer clothing and placing the patient in a recumbent position, the contour of the abdomen was noted as being that of pregnancy; by palpation motion was distinctly felt. The case was at once pronounced one of pregnancy. On questioning the patient, she acknowledged she felt that sensation about one week previous. She could not think it possible; she thought she had passed the climacteric.

Keeping the case under careful observation, it was found there was a gradual increase in the size of the abdomen, as well as a raising of the tumor towards the sternum.

The mammæ increased in size and became firm. The functions of the body are normal; no nausea, neither had she any with her other pregnancies. She complained of sleepiness, she could hardly keep awake; she was affected in the same way with the other pregnancies. She has felt motion frequently up to the present time. Counting from the period of quickening, parturition may take place from the twenty-sixth to the end of the month.

An attempt was made to photograph this case by the X-rays, but did not prove successful, the apparatus not working satisfactorily. Thanks are due to Drs. Pitcairn, Gaggin and Blair, of the Homœopathic Hospital, Pittsburg, for the attempt.

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CASE II.—Technically this case should come under some other caption, but for want of a better is reported under this head.

Mrs. S.; age, 38; fair complexion, light-brown hair, and gray eyes; height about five feet two or three inches; weight, 135 or 140 pounds.

Family history: Father still living, in good health; mother died some years since of heart disease, from which she suffered from the time she was twelve or thirteen years old, when she had rheumatism, which left her with the heart disease. One sister died very suddenly after an attack of pneumonia, the attending physician having discharged her but an hour or so before. A brother died but a few days since from consumption, the result of irregular living.

Two years ago this September she had hæmorrhage from the kidneys; the urine looking like pure blood, only more watery. By nitric test nearly one-half was solid matter.

The remedies were terebinthina, 3x. The hæmorrhage was checked in about a week's time. Arsenicum, 6x, was given subsequently for later symptoms that developed. In about one month's time she apparently made a recovery.

The attack was supposed to have been superinduced by the *over use* of the bicycle.

She had been riding nearly every day during July and August (the weather most of the time very hot) ten and twelve miles, and frequently much greater distances. After returning she would attend to her household duties and her five children.

She remained in apparently good health for over a year, when she became pregnant. There were no unusual manifestations, except an insatiable appetite, for which she received nux vomica, 3x, and later anacardium, which relieved.

About the seventh month there was considerable pain, threatening miscarriage. Cimicifuga, 3x, relieved the pains. There was a general bloating. The urine test gave no indication of albumin. Arsenicum, 6x, relieved the bloating.

The cimicifuga was continued off and on during the last two months, as the pain indicated. She seemed in good spirits during the pregnancy, but declared from the first she would

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not recover. She made arrangements for her departure, as if she knew she was going on a visit.

On the evening of the 19th of June she ate a hearty evening dinner, and seemed very jovial. About eight o'clock felt a fainting sensation, although she did not lose consciousness. To use her own words, "She felt herself getting white."

She had gone ten days over the 280. About nine o'clock, when I reached her, the pallor of the face, ears and lips caused some anxiety. She complained of dizziness when she stood on her feet. This was attributed to flatulence. She rifted large quantities of gas. This condition had attended all of her confinements. She seemed very apprehensive of the manner in which labor had manifested itself; it was difficult to allay her fears. Labor progressed in the normal way; bowels and urine in good condition.

During the first examination the hand was discolored by blood. This caused uneasiness, lest a case of placenta prævia was threatening. Later, when the membrane ruptured, the amniotic fluid stained the clothing a pink color.

About four o'clock the pains indicated delivery would not long be delayed. Genuine labor did not last over an hour; was normal in every other way. She pleaded for chloroform, but she had none till during the last two or three pains, and then only enough to soothe. As she would say, "That is enough" (she had chloroform in all her labors excepting the one previous). The head was delivered without any difficulty. After the head there was a delay of from ten to fifteen minutes before the shoulders came, and then the use of strong traction, made by hooking the forefingers in the axillæ, the body was followed by a clot of blood as large as the child's head. The cord had ceased to beat. The placenta and membranes were removed immediately. They were followed by considerable hæmorrhage. The child never breathed. Although friction, hot and cold baths, dilatation of rectum, and the usual methods for resuscitation were resorted to, there was no response.

The child was handed over to the nurse, and the mother given undivided attention. She received china, 3x, and a half cup of hot milk. The womb had contracted down firmly. The

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soiled clothing was removed, and she rested quietly from fifteen to twenty minutes; then she said, "What has gone wrong? something has gone wrong; is my baby dead? Oh, I thought I would have my baby in my arms." We quieted her as best we could. She rested quietly a few minutes, then complained of feeling queer, and asked for more hot milk, previous to which china was again administered. She rifted a large quantity of gas, and said, "There, I feel better; can I go to sleep?" She was told she could sleep all she wanted to. After some ten or fifteen minutes she said, "There, I feel it coming again; rub my arms and limbs," which was done. The pulse fluctuated, and the surface of the body became cold and clammy. Veratrum was given. She rallied; the pulse became stronger, and she again rested quietly. After a few minutes she said, "Doctor, you have done all you could, but I am not going to get over this." She then gave some messages to her husband. Her pulse again failed; stimulants were administered; she again rallied, and the heart's action was firm and regular for a short period, when she went into a convulsion, throwing herself from side to side of the bed, the attendants being unable to hold her. Chloroform quieted her in a few minutes, she saying, "That is enough." Within five minutes the second convulsion came on, which was quickly checked by the chloroform. After a short interval the third; but it aborted. The pulse was failing, the foam was being blown from the mouth. In fifteen or twenty minutes all was over, the breathing becoming shorter and at longer intervals; there was no struggle; we hardly knew when the last breath was taken. In less than one hour and a half after the birth of the child all was over. The consultant sent for came half an hour after the patient had gone.

The child was a male; weighed eleven pounds; perfectly developed; down the front of both arms, the whole length, a water-blister a quarter of an inch at the base, no doubt caused by the pressure. The labor was not difficult nor protracted. There was no occasion to use instruments. This was the sixth confinement, and in all but this one and the one previous had been difficult and instruments and anæsthetics were used. The

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one previous was tedious but not difficult. With both of these pregnancies she had taken cimicifuga for nearly two months (intermittingly). With her first delivery she was torn to the rectum, and nothing had been done to rectify the injury.

Within twenty-four hours after her death she was so swollen and changed her friends could not recognize one feature. This in part was due to the failure of the undertaker to properly do the embalming.

Did not the child die at the time the mother fainted? Were not the convulsions and death the result of the previously-diseased condition of the kidneys?

Her strength kept up till the head was delivered; then began to fail, and when delivery was completed she simply collapsed.

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CASES ILLUSTRATING BRAIN LOCALIZATION AND BRAIN SURGERY.*

WESTON D. BAYLEY, M.D., AND CARL V. VISCHER, M.D.,
PHILADELPHIA.

THE following cases are reported because of their general clinical interest; and because such cases should always be placed upon record that collectively they may give us statistics of the greatest importance in formulating the indications for and estimating the value of operation.

CASE I.—Male; age, 63 years; who was well, excepting for several slight attacks of vertigo, until July 19, 1896. On this day, between rising and breakfast, he noticed a "faint giddy feeling about his head." This caused him to sit still for a few minutes, then he went to breakfast. During the week following he had similar vertiginous attacks, which seemed to increase somewhat in severity each day. He is rather confused about his history at this time, but at the end of the week he discovered that while apparently able to see quite well he could not READ, that is, he could not make out the meaning of written or printed characters—he could see but he could not discern. For this reason he could not copy any writing, although he could compose and write from dictation fairly well. A week later he had much burning pain in the left eye; this has diminished, but exists in slight degree to the present. He is otherwise in fair health, and applies for an explanation of his symptoms. An examination does not give much additional information. There is no hemianopsia; the optic nerve is normal; urinary examination negative; he cannot make out any letters on a spelling-card, although he can see everything in the room. He has had no headaches; is right-handed; has no motor aphasia. Father died of fatty heart; mother of some chronic

* This paper was received too late for insertion in the Report of the Bureau of Surgery.

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disease, the nature of which is unknown; no venereal disease; knee-jerks equal and rather free; no ankle clonus. We are obviously dealing with a case of alexia, or as it is called, word-blindness, or the loss of the visual memory for words, the centre for which, in right-handed people, is in the left parietal lobe posterior to the upturned extremity of the fissure of Sylvius. The lesion is most likely cortical, for if deep in this locality there will be hemianæsthesia. It is probably limited to this area, because if it extends anteriorly there would be some motor impairment, or posteriorly, hemianopsia. From the patient's age and the manner of onset of his symptoms, it is most likely a cortical hæmorrhage. With these data and this presumptive diagnosis, an exploratory trephining is advised. This was done on August 27, 1896. After the usual preparation, the parietal boss was exposed on the left side and an inch and a quarter trephine opening was made immediately behind it, this having been somewhat enlarged, there being no brain pulsations present, the dura was incised. The brain presented an unhealthy appearance. A sub-cortical exploration with the trocar revealed a recent blood cyst, the walls and adjacent brain were softened. The cyst having been evacuated and its cavity cleansed, the dura was sutured and the wound completely closed. Recovery from the operation occurred without incident. An examination made at the time of final removal of the dressings showed some improvement in the patient's ability to understand printed letters—he could, with the alphabet card, distinguish correctly perhaps two out of three, and with difficulty and hesitation could spell out some words. He is otherwise as before the operation, excepting that an examination shows a right-sided hemianopsia, and fields taken by Dr. Jessup show an abrupt central termination. Word received quite recently from the patient announces slight further improvement in his ability to discern the meaning of letters.

Case II.—Male; age, 45; was seen August 2, 1896, with the following history: Left-sided otorrhœa at intervals since infancy. Has had several attacks of acute pain, none, however, as severe as the present one. This attack came on while he was on a trip in the latter part of July, 1896. The pains be-

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gan in the ear, extended to the head, and he came home almost delirious with their severity. There was tenderness all over the left side of the head. No mastoid swelling. He had fever and some delirium. Could not recall the names of those about him. At this time the knee-jerks were normal and there was no ankle clonus. Dr. Shallcross concurred in the opinion of the writers that the mastoid should be immediately opened. Having prepared the field of operation in the usual manner, an incision was made just posterior to the pinna and the entire mastoid exposed, after which the antrum was opened in the supra meatal triangle of MacEwen (this being a space bounded by the lower posterior root of the zygoma and the superior posterior edge of the external auditory canal); the bone was found unusually thick. On entering the cavity nothing save a few bubbles of air escaped, and the opening of the mastoid proper was with negative result.

Following the operation, the pain and delirium ceased, but the amnesic aphasia was very pronounced. He could not recall ordinary nouns, especially names of places and people. Did not know the name of a mileage-book which was handed him, although he had used them for years. Calls a conductor a "passenger," and afterwards a "postal card," thus showing a degree of paraphasia. The knee-jerks are now exaggerated, especially the right, and there is right-sided ankle clonus. In the course of a few days the pain returned. This was worse at night, and his headaches were especially severe on the right side of the head. He was very irritable, delirious, and threatened suicide. Early in the morning of August 11 he was trephined one and a quarter inch behind, and one and a half inch above the external auditory meatus, the indications being clearly that there was an abscess in the temporal lobe. On removal of the button of bone the brain protruded; the meninges were quite injected, and there was an entire absence of pulsation. The trephine opening was now enlarged upward and forward, after which the dura was incised. On palpating the brain distinct fluctuation could be elicited. The cortex was incised, and this gave vent to a gush of thin, foul-smelling pus some ounce and a half in quantity. On introducing the finger

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a cavity, the size of a hen's egg, extending anteriorly and toward the median line, with apparently a well-defined wall, could be made out. This was thoroughly irrigated with a boric acid solution and then packed with sterile gauze wrung out of the same solution. The wound in the dura was for the greater part closed, allowing merely sufficient opening at the most dependant portion to ensure good drainage. After a few days the gauze drain was replaced by a glass tube because the latter would better drain the pus which had changed to a rather thick creamy consistency. The cavity was also first cleansed with peroxide of hydrogen (full strength), and afterwards irrigated with boric acid solution. Healing progressed rapidly, the cavity gradually becoming obliterated from the bottom.

A subsequent examination of the reflexes showed the knee-jerks to be free, but less than before the operation. The ankle clonus was not now present. The degree of amnesia since the operation has varied—some days he would be quite aphasic, and again the aphasia was only shown by an occasional lapse in conversation. The general tendency is towards improvement.

Case III.—Boy; age, 14 years, who was well until eight months of age, when he fell, striking the left side of his head against a range. This occurred at 8 A.M.; he cried some, but was seemingly all right the rest of the day. In the evening he became drowsy, and went into convulsions, which were entirely limited to the *left* side. These continued for several hours, and were followed by coma. In the morning he was aroused, but was found to have a left-sided hemiplegia, and he could not make use of his left side for a month. During the first week following the convulsions he would frequently have symptoms as of impending convulsions, but they did not supervene. After this, at intervals of from two to six months, he would have convulsions similar to the first one, always with a subsequent paresis of the left side. These of late have been more frequent and quite severe. They are of some minutes' duration, but of late have not been followed by such marked weakness of the left side. Does not bite his tongue. Sometimes there are abortive attacks in which "his speech gets

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thick and saliva dribbles." He repeatedly masturbates during sleep, which is often restless, and the occasion of moaning and incoherent talking. It is learned that the convulsive twitchings always begin in the face before the arm or leg are affected; indeed of late the arm and leg are not involved so severely as heretofore, but the facial movements do not improve. Knee-jerks are free; no ankle clonus. The conclusion reached is, that there was a slow traumatic hæmorrhage, most likely meningeal, in the Rolandic region, at the time of the injury in infancy. An exploratory trephining was advised.

Now a word about trephining for focal or Jacksonian epilepsy. The results have been rather disappointing, as might be inferred. A clot may have been absorbed and left simply cortical instability as evidence of its former presence. This will not be benefited by operation. Again, secondary degenerative changes may have descended through the fibres of the corona even to the spinal cord. We can usually distinguish this condition; there is no use in trephining in the hope of cure then. So that trephining in these cases is simply an explorative procedure, often a mere measure of diagnosis.

In this case a trephine opening of one and a quarter inches was made over the lower Rolandic area of the right side and enlarged upwards. The dura was incised, and no evidence of any pathological change found. The wound was closed, and an uninterrupted recovery followed. He has had no convulsion since the operation, and his health is very good. But there has not been sufficient lapse of time to make observations of any value.

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HAHNEMANN'S TOMB AND INTERNATIONAL MONUMENT IN PARIS.

Dr. Bushrod W. James, who had just returned from the International Homœopathic Medical Congress held in London, Eng., reported that the Congress had taken up the matter of placing a monument or some suitable memorial-tablet over the remains of Hahnemann in the Montmartre Cemetery, Paris, France.

Dr. L. Brazol, of St. Petersburg, brought the matter before the Congress, and a Commission on Hahnemann's Tomb and International Monument was appointed, consisting of Dr. Leon Brazol, St. Petersburg, Russia; Dr. F. Cartier, Paris, France; Dr. Alex. Villers, of Dresden, Germany; and Dr. Bushrod W. James, Philadelphia, Pa.

The Commission met and considered the subject, and made a report to the Congress before its adjournment, which was unanimously adopted and the committee continued.

It was considered best that a conference should first be had with the French Homœopathic Society in order to know what they were likely to do or wished to do before preparing plans for carrying out the project. Dr. Cartier was empowered to obtain this desired information. Dr. Brazol was made chairman and Dr. Cartier secretary.

Dr. Cartier subsequently presented the matter to the French Society in order that initiative steps should be taken.

One of the main points which had to be considered was that of obtaining permission of the proper authorities for the erection of the monument in the lot where he is buried. This matter will, in all probability, be attended to by Dr. Cartier and the French Society.

Another point discussed by the committee was how to raise the funds for the purpose. No definite decision was made on this point, but the general opinion seemed to be that

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the various homœopathic societies of the world would want to take part in subscribing toward this great object, and that many homœopathic practitioners and members of the laity would feel grateful enough to the founder of the great medical reform—Homœopathy—to subscribe liberally in honor of Hahnemann.

At this time the committee is awaiting definite action as to what further steps are required to be taken to accomplish the object desired.

Inasmuch as the Congress decided that the next International Congress be held in Paris in 1900, it is hoped that the committee will be able to finish its work before that time.

This Society is not asked to take any special action at the present time, but to keep the matter under consideration for action at some subsequent meeting of the State Society.

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